Orientation of New Local Public Health Administrators in Washington State

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Prepared for the Public Health Executive Leaders Forum and the Washington State Department of Health by

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Washington State New Local Public Health Administrators

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Washington State Public Health Administrators Orientation

Background

Although many new public health administrators have prior training or experience in public health and/or in administration, only a few are prepared to immediately assume the full range of administrator responsibilities. An orientation to the Washington State public health system, with mentoring and readily available resource materials could help all new administrators perform their duties more effectively and have a positive impact on the practice of public health in the state.

Through its various forums, the Washington State Association of Local Public Health Officials (WSALPHO), in collaboration with DOH, has developed several orientation processes for four types of public health (PH) leaders. The Public Health Executive Leadership Forum (PHELF) has taken the lead in developing an orientation for PH Administrators. PHELF is an organization made up of individuals who are in leadership positions and are responsible for directing and administering the public health programs in local health jurisdictions (LHJ) across the state. Membership includes LHJ Administrators and Health Officers. This orientation manual is for LHJ leaders who perform the function of administrator whether their position is “Administrator for Health”, “Administrator for Health and Human Services”, or Administrator with other roles within the LHJ. The Health Officers have a separate orientation manual and process, as do the Nursing Directors and the Environmental Health Directors.

The position of Administrator spans a wide range of expertise, knowledge, and skill. It is assumed that the selection process has identified an individual with proven abilities to work successfully with governing boards and with volunteers, to direct and mentor managers and other staff, and to communicate with the public on a routine basis. In addition, the Administrator must be able to develop and track budgets, administer programs, set priorities and goals, write proposals for grants and other funding, oversee contracts, and evaluate program performance.

The “Orientation of New Local Public Health Administrators in Washington State” was developed to help prepare new leadership for the challenging work that lies ahead. It provides an overview of public health in Washington State, an introduction to many aspects of leading a local health jurisdiction and a variety of methods to learn more about both. The orientation is not designed to provide basic skills or knowledge in administration, but is intended as a framework to increase levels of skill and knowledge in specific areas of public health over time.

Although this document establishes an orientation process for administrators beginning in July of 2001, it is anticipated that the roles and responsibilities will change. In addition, it is likely that new training materials and resources will become available. To respond to these changes, the orientation process should be dynamic in nature. This will require ongoing and periodic evaluations of the process by PHELF and other persons involved in the orientation process.

Purpose

The goal of this orientation is to improve work performance of local public health administrators in Washington State (including their facilitation of work done by others) and increase their level of job comfort. It is recommended that all new LHJ administrative leaders, regardless of the specific title, who are recognized as having significant responsibility and influence over the entire agency will participate in this orientation process.

Objectives

After completing the orientation process, new local public health administrators will:

1. Have a better understanding of the framework and operations of the public health system in Washington State and in their local health jurisdiction.
2. Be familiar with the key agencies and personnel in public health at the state and local level.
3. Be able to list the typical roles and responsibilities of local public health administrators.
4. Be able to identify resources (including written references and human contacts) to support their work.
5. Be able to access other LHJ administrators for consultation and mutual support.
6. Perform selected job activities with increased knowledge and skill.

Framework for the Orientation

The orientation process has been developed to provide information and training in eight major knowledge areas prioritized by the Local Public Health Administrator Orientation Work Group, a subgroup of PHELF. These areas provide the organizing framework for the orientation content and materials. This orientation manual contains some basic information and a self-assessment for these knowledge areas located in Tabs 1-8. The knowledge areas include:

1. Washington State Public Health System
2. Boards of Health and the Legal Authority of Public Health
3. Organizational Structures of Local Health Jurisdictions
4. Funding Sources, Contracts, and Reports
5. Public Relations and Community Involvement
6. Health Policy Development and Implementation
7. Personnel and Property Management
8. Information Systems and Technology

Public Health Skills and Knowledge

Upon completing the Local Public Health Administrator's orientation, a new administrator will demonstrate skills and knowledge in:

1. Public Health System in Washington State

- Functions and relationships of the Department of Health, and other key state agencies, associations, and forums
- Three core functions and the 10 Essential Public Health Services and the relationship to programs and services
- Appropriate role for public health and the local health jurisdiction in a given community
- Washington State Public Health Improvement Plan (PHIP) and the Public Health Performance Standards

2. Legal Authority of Public Health and Boards of Health

- Legal authority and differing roles of state and local public health and the state and local Boards of Health
- WACs (Washington Administrative Code) and RCWs (Revised Code of Washington) governing public health, including how to find applicable laws and regulations
- Appropriate participation in local Board of Health (LBOH) agendas and meetings
- Board development and member orientation
- Appropriate process to address a public health issue with LBOH through problem identification, discussion, development of action plans, and review
- Role, functions and development of collaborative relationship with County Legal Counsel

3. Organizational Structures of Local Health Jurisdictions

- Distinctions between health departments, districts, and multi-county districts; the pros and cons of alternative structures, and the implications for LHJ operations
- Key LHJ functions and programs such as Environmental Health, Personal Health Services, Communicable Disease, Assessment, and various arrangements of these functions inside or outside of the LHJ
- Key management and operations staff of their local health jurisdiction
- Priority public health problems and activities in the local community, including demographics, health indicator data and community health status
- LHJ policies and procedures for daily operations (e.g. confidentiality policy or health alert procedure)

Public Health Skills and Knowledge (cont'd)

4. Funding Sources, Contracts and Reports

- Funding and revenue sources for the LHJ and the key financial reports describing LHJ expenditures and financial activity
- Annual budgeting cycle and expectations of the LHJ administrator for development and management of the annual budget
- Components of the Consolidated Contract between DOH and the LHJ, the programs funded through the contract, the associated deliverables and reporting requirements
- Other major contracts with DOH or county government which provide funding for key LHJ programs
- Contractors and vendors that generate expenditures for the LHJ

5. Public Relations and Community Involvement

- Policies and procedures for interaction with the media for distribution of information and press releases
- Interactions with legislators in response to inquiries or to communicate alerts regarding a health issue
- Appropriate people/groups (in and outside the local health jurisdiction) to include in a meeting or discussion about a particular public health problem/initiative
- Communication processes with key partners to assure communications occur in a timely manner, are directed at the most appropriate person(s), and meet the desired purpose
- Representation of the LHJ on task forces and committees at state and local levels, and with other providers, private agencies and the community

6. Health Policy Development and Implementation

- Development and achievement of mission, goals and objectives as part of the Strategic Plan for the LHJ
- Development of public health policy at local and state levels, including public health law found in RCWs, WACs, and ordinances
- Implementation of established public health policies at the local level
- Facilitation and/or leading specific program planning and evaluation activities
- Community health assessment activities and the analysis of health indicator data to identify health issues needing improvement
- Application of public health standards and best practices to improve services and programs at their local health jurisdiction
- Involvement in the continued implementation of the Public Health Improvement Plan

Public Health Skills and Knowledge (cont'd)

7. Personnel and Property Management

- Administration of personnel policies and procedures through knowledge of laws and regulations and interpretation into operational procedures
- Labor relations and union contract issues, as appropriate
- Motivation, direction, and training of managerial staff for the LHJ
- Maintenance of LHJ property, facilities, and grounds and the available resources
- County regulations regarding use/lease of property
- Control and condition of LHJ equipment including purchasing and capital expenditures/acquisitions

8. Information Systems and Technology

- Key electronic systems available to document and track administrative and clinical public health activities
- Use of email to support administrative work including various listservs and online conferencing capabilities
- Confidentiality laws and regulations, including Health Insurance Portability and Accountability Act (HIPAA) and a self-assessment
- Website management and oversight

Orientation Process

The orientation is an ongoing process that begins before the new local administrator is hired (i.e., with the local health jurisdiction's recruitment efforts) and continues until the new administrator feels comfortable with his/her duties and responsibilities. DOH, WSALPHO, the new administrator, the hiring agent, the advisor administrator, and his/her local health jurisdiction all share in the responsibilities for the orientation process.

Figure 1 describes the steps in the orientation process and the persons/groups responsible for completion of each step. Key steps include being assigned a mentor and undertaking the recommended self-study orientation. Although it is suggested that all steps of the orientation be completed, they may occur in a different order or, depending on the new administrator's background and experience may not be necessary at all.

Step 1: **DOH and WSALPHO are notified of new Administrator appointment.** (Responsibility: Hiring agent) The hiring agent notifies DOH Office of Public Health Systems Planning & Development and the WSALPHO administrator of the hiring of a new local public health administrator.

Orientation Process (cont'd)

Step 2: **Administrator appointment is communicated throughout DOH and WSALPHO.** (Responsibility: DOH Office of Public Health Systems Planning & Development, WSALPHO) The DOH Local Health Liaison will contact the new administrator and send them the orientation materials and manual.

- name and address of new administrator is communicated to all DOH programs and all other LHJs in Washington State
- local health jurisdiction directory is updated
- email address is added to address book for agency
- name and email address are added to WSALPHO listserv and mailing list and to PHELF listserv

Step 3: **PHELF Chair or Vice-Chair contacts new administrator.** PHELF officer contacts the new local administrator and reviews the general orientation process (including the manual, self-assessments, and toolkit), discusses selection of comparable LHJ to identify an administrator to serve as a mentor, helps deal with any immediate problems, and invites the new administrator to the next PHELF meeting. Offers to meet with the new administrator if needed (optional).

Step 4: **A mentor administrator is identified and contacts the new administrator by phone at least twice within first month.** (Responsibility: PHELF Chair or Vice-Chair) Candidates are contacted, informed of responsibilities, and asked about availability/willingness to be a mentor. The new mentor makes contact with the new administrator at least twice during the first month and ad hoc thereafter.

Step 5: **Development and review of individual orientation plan.** (Responsibility: Hiring agent, new local administrator, and mentor) The new administrator uses the self-assessments and orientation toolkit to develop their individualized orientation plan. The new administrator then reviews and finalizes the individual orientation plan with the hiring agent and the mentor. The final orientation plan is sent with the new administrator's biography sheet (page xii) to the DOH Learning Resource Center.

Step 6: **Orientation/training occurs, largely self-guided by new administrator.** (Responsibility: hiring agent, new administrator, mentor, and DOH Office of Public Health Systems Planning & Development [Learning Resource Coordinator and Local Health Liaison]) Appropriate documents, reference books, and other materials (from Orientation Toolkit) are packaged and sent to new administrator. Requested meetings are arranged. As needed, the new administrator contacts their hiring agent, their mentor, the DOH Local Health Liaison, or the DOH Learning Resource Coordinator for assistance.

Step 7: **Orientation process continues until new administrator feels comfortable with roles and responsibilities.** (Responsibility: hiring agent, new administrator, mentor, and Local Health Liaison)

Step 8: **Orientation process is evaluated.** (Responsibility: DOH Office of Public Health Systems Planning & Development [Learning Resource Coordinator], Local Health Liaison, hiring agent, mentor, and new administrator)

The DOH orientation activities should in no way inhibit or interfere with orientation activities coordinated by other groups. Furthermore, where possible, efforts should be made to combine and streamline orientation activities from different sources.

Orientation of New Local Public Health Administrators

[Place holder for Orientation steps Picture—Need from Marie]

Resources and Activities

The LHJ Administrator orientation process is largely self-guided and consists of a collection of materials and activities through which the administrator can learn about public health, their local health jurisdiction, the health of their community, and the major roles and responsibilities of a local health administrator. The process is to be customized to meet individual needs and includes a variety of learning resources:

- basic content in the orientation manual in the eight knowledge areas,
- a self-assessment at the end of each knowledge content area to guide the development of the administrator's individual orientation plan,
- a toolkit to document the individual's orientation plan based on the selection of orientation options consisting of suggested written and online materials/references and of various orientation activities,
- recommended meetings with key people at both state and local levels,
- individual support from a more experienced local health administrator, and
- meeting with other administrators through PHELF and WSALPHO.

Mentor System

The PH Administrator Mentor System consists of pairing an experienced administrator from a similar LHJ with each new administrator in Washington State. The purpose of the system is to provide an informal mentoring relationship for the new administrator in the performance of his/her duties during his/her initial months on the job. The mentor and the new administrator will develop their relationship and style of interaction with minimal oversight. The chair or vice-chair of the PHELF will arrange for the mentor relationship, and will assist the orientation of the new administrator as needed. The DOH Learning Resource Coordinator will support the process where requested. During the orientation period, the mentor will provide the following services:

- Be available by telephone during normal working hours for consultation with the new administrator on specific problems and issues as they arise.
- Review (verbally or in person) the individual orientation plan developed by the new administrator to advise them on other available resources.
- Link the new administrator with other knowledgeable individuals within public health and the community (e.g. other administrators, WSALPHO members, or DOH staff).
- Inform the PHELF chair or vice-chair if there are any problems with the new administrator/mentor relationship.
- Participate in the evaluation of the orientation process.

Directions for Completion of Orientation Process

Completing the Self-Assessment

In order to develop their individualized orientation plan, the new administrator will complete the self-assessment located at the end of each knowledge area section of this manual. The self-assessment assists the individual in determining their level of proficiency in each of the items for the knowledge area. The levels of proficiency are the same levels used by DOH to define core competencies for the state DOH strategic plan. These are based on the Core Legal Competencies for Public Health Practitioners developed by the Center for Law and the Public's Health. The three levels of proficiency are:

1. Aware: Basic level of mastery. Individuals may be able to identify the concept or skill, but have limited ability to perform the skill or apply the concept in their work.

2. Knowledgeable: Intermediate level of mastery. Individuals are able to apply and describe the skill or concept.

3. Proficient: Advanced level of mastery. Individuals are able to synthesize, critique or teach the skill.

The self-assessment will help the new administrator identify appropriate activities and orientation opportunities from the Orientation Toolkit based on their current level of proficiency and past experience.

Developing the Orientation Plan by Using the Toolkit

The Orientation Toolkit is designed to document the individual's orientation plan through the selection of orientation activities by the new administrator. Each item in the toolkit has space for the administrator to indicate if that item will be part of their orientation, and to document when they have completed that reference or activity. Orientation activities can be supplemented with other available materials/activities, such as content found in Tabs 1-8 in the orientation manual.

To help prioritize specific orientation options, the written and online references and the orientation activities are ranked according to the following categories:

Basic Level	These references and activities are for administrators with no proficiency or an "aware" level of proficiency in the related knowledge area.
Secondary Level	These references and activities will increase proficiency for administrators with a "knowledgeable" level of proficiency.
Additional Items	These references provide more detailed knowledge in a particular area for administrators who are at a "proficient" level or have an interest in the topic.

These rankings of orientation options should not be strictly applied due to overlap in the categories, differing priorities for each administrator, and the ongoing nature of the orientation process.

Finalizing the Orientation Plan

The new administrator should review their orientation plan with their hiring agent (or HR) and mentor to learn of other activities to address needed areas or make revisions based on a more experienced person's knowledge of available resources. The orientation plan will then serve as an "order form" to request orientation materials or the arrangement of certain meetings. A copy of the initial orientation plan should be forwarded to the Washington State Department of Health Learning Resource Coordinator. During the orientation period, the new administrator should feel free to request additional items from the Learning Resource Coordinator or discuss the inclusion of items not listed in the orientation toolkit.

Conducting the Orientation Process

Over the course of the first year in the administrator position, the new administrator should complete as many of the orientation activities as possible. If the new administrator encounters any difficulty in completing the orientation, they should contact either their mentor or the hiring agent to determine how to proceed with the orientation activities. As each activity is completed, the new administrator should note the date and any comments regarding the materials or activity in the first column of the toolkit referencing that item.

Evaluation of the Orientation Process

Each new administrator will evaluate the orientation process after 12 months in the position, or as soon as possible thereafter. The evaluation will include an interview with the new administrator, the hiring agent, and the mentor by the DOH Learning Resource Coordinator. At least once each year, PHELF will review the new local administrator orientation process. The group will be asked to review results from ongoing or completed orientations and consider new needs in public health administration. Administrators currently participating in the orientation process (or those who have completed it since the last discussion) will be asked to highlight their experiences including any problems encountered. Recommendations for revisions to the orientation process or content will be sent to the DOH Learning Resource Coordinator for further action.

Acknowledgment

The PH Administrator Orientation Workgroup has developed this orientation manual and process for members of the Public Health Executive Leadership Forum of Washington State. Some of the formatting and content have been taken from the orientation manuals developed for Health Officers, Environmental Health Directors and Nursing Directors. PHELF and the Washington State Department of Health wish to thank the following contributors for their time, suggestions, and participation:

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New Administrator Biography

This form should be completed before initiating orientation activities and sent to the DOH Learning Resources Center. The information will be used to update the Washington State Public Health Administrator Roster and the WSALPHO Directory. Any questions about this form or the menu should be directed to: Learning Resource Coordinator, 1102 SE Quince Street, or PO Box 47815, Olympia, WA 98504-7815, (360) 236-4081 PHONE, (360) 236-4088 FAX, waphtn@doh.wa.gov

Name: _____

CONTACT INFORMATION

Mailing address: _____

_____

Telephone number: _____ FAX number: _____

Beeper number: _____ Email address: _____

Cellular phone number: _____

Beginning date as Public Health Administrator: _____

For which jurisdiction: _____

EDUCATION

Bachelor's degree: Yes ___ No ___ If yes, specify major: _____

MPH or other Master's degree: Yes ___ No ___ If yes, specify major: _____

Doctoral degree: Yes ___ No ___ If yes, specify major: _____

Other: Yes ___ No ___ If yes, specify specialty: _____

EXPERIENCE

Clinical experience:

Public health experience:

Tab 1

Public Health System in Washington State

The Washington State Public Health System

Establishing the Department of Health

Originally, the framers of the Washington State Constitution provided for a state board of health in the constitution. Article XX provides that *"there shall be established by law a state board of health and a bureau of vital statistics in connection therewith, with such powers as the legislature may direct."* The board began operations in 1891. The Department of Health was formed in 1921. The department became a division of the Department of Social and Health Services (DSHS) in 1970.

General dissatisfaction with public health policy and lack of financial assistance from the Health Services Division of DSHS led to discussions of recreating a State Department of Health in the mid-1980s. Efforts to reestablish a State Department of Health began in earnest in 1987. Governor Booth Gardner in the waning moments of the 1989 legislative session became an advocate for a new department. The House Health Care Committee (with Dennis Braddock as Chair) drafted legislation strengthening the authority of the State Board of Health and creating a State Department of Health in 1989 through RCW 43.70.020.

The mission of the Department of Health is to protect and improve the health of the people in Washington State. The Department has the primary responsibility for preserving public health, monitoring health care costs, maintaining minimal standards for quality health care delivery, and generally overseeing and planning for all the state's activities as they relate to the health of its citizenry.

The Role of Public Health

State and local health agencies protect and promote health, and prevent disease and injury. Public health services are population based, focusing on improving the health status of the population, rather than treating individuals. This responsibility is shared by the State Department of Health and the 34 local health jurisdictions which serve Washington's 39 counties. The role of government in public health protection was well articulated by the 1988 Institute of Medicine (IOM) report that cited three primary responsibilities. Called the three core functions, they are:

- **Assessment:** To identify trends in illness and death and the factors which may cause these events, as well as available health resources and their application, unmet needs, and citizens' perceptions about their health.
- **Policy Development:** The information taken from the assessment data is used to develop state and local health policies. Policies are incorporated into community priorities and plans, public agency budgets, and local ordinances and statutes.
- **Assurance**: This function translates the policies into services and monitoring of the quality of all health services provided in both the private and the public sectors.

1990's Health Care Reform

In the 1980's annual double-digit health care cost increases were affecting businesses and government employers. In 1988, the Washington Health Care Commission was established to assess the problem and recommend solutions to address the crisis. The close of the 1992 legislative session and completion of the Washington Health Care Commission Report set the stage for Health Care Reform during the 1993 legislative session. Key staff from the Senate and House committees responsible for health care issues met with the Washington State Association of Local Public Health Officials (WSALPHO) advising them that Health Care Reform would be the consuming legislative effort in 1993.

WSALPHO recognized that the new emphasis on Health Care Reform was an opportunity to secure appropriate levels of state funding of local public health. WSALPHO assembled a work group to determine the state's contribution to assure adequate public health protection in Washington State. The Health Services Act of 1993 included public health as a part of health care services essential to the public. The down payment for funding the state's portion of public health was tied to services to be outlined in the Public Health Improvement Plan, which was scheduled to be delivered to the legislature by December 1994.

Public Health Improvement Plan/Partnership (PHIP)

Since 1994, Washington's public health system has collaborated in the development of the Public Health Improvement Plan (PHIP). The PHIP is updated biennially; the latest edition was published in December 2000. The plan is designed to evaluate and make recommendations for improvement in the delivery of public health services in Washington. The plan is developed in partnership with Department of Health, the state's 34 local health jurisdictions, the University of Washington School of Public Health, and the State Board of Health. Future reports will be called the Public Health Improvement Partnership. There are seven components of the 2000 plan, including:

- Key Health Indicators,
- Standards for Public Health in Washington State,
- Information Technology Planning,
- Workforce Development,
- Financing Public Health,
- Access to Critical Services, and
- Communications

One of these components, the Public Health Performance Standards, forms a performance measurement system for five major areas of public health practice. These five areas include Assessment, Protecting People from Communicable Diseases, Environmental Health, Health Education and Promotion, and Helping People Get Needed Services. The standards describe the policies, procedures, and activities that must be in place at the state and local level to evaluate and protect public health in Washington. For each standard, a set of measures is provided for local and state agencies. The standards and measures crosswalk to the ten essential public health services and the three core functions of public health.

Federal Agencies

Numerous federal agencies influence or contribute regulations, funding, consultation and technical assistance, and/or assessment information to local health jurisdictions. Some of these agencies and groups are described below. Many others are referenced in the Orientation Toolkit under the Public Health System knowledge area, with descriptions of their function, websites and contact information.

Center for Disease Control (CDC) – http://www.cdc.gov/aboutcdc
The Centers for Disease Control and Prevention (CDC) is located in Atlanta, Georgia, is an agency of the Department of Health and Human Services. The CDC is recognized as the lead federal agency for protecting the health and safety of people - at home and abroad, providing credible information to enhance health decisions, and promoting health through strong partnerships. The mission of CDC is to promote health and quality of life by preventing and controlling disease, injury, and disability. CDC serves as the national focus for developing and applying disease prevention and control, environmental health, and health promotion and education activities designed to improve the health of the people of the United States.

CDC has developed and sustained many vital partnerships with public and private entities that improve service to the American people. In FY 2000, the workforce of CDC comprised approximately 8,500 FTE in 170 disciplines with a public health focus. Although CDC's national headquarters is in Atlanta, Georgia, more than 2,000 CDC employees work at other locations, including 47 state health departments. Approximately 120 are assigned overseas in 45 countries. CDC includes 12 Centers, Institutes, and Offices.

- National Center on Birth Defects and Developmental Disabilities
- National Center for Chronic Disease Prevention and Health Promotion
- National Center for Environmental Health
  Office of Genetics and Disease Prevention
- National Center for Health Statistics
- National Center for HIV, STD, and TB Prevention
- National Center for Infectious Diseases
- National Center for Injury Prevention and Control
- National Immunization Program
- National Institute for Occupational Safety and Health
- Epidemiology Program Office
- Public Health Practice Program Office

Agency for Toxic Substances and Disease Registry (ATSDR) - CDC performs many of the administrative functions for the Agency for Toxic Substances and Disease Registry (ATSDR), a sister agency of CDC, and one of eight federal public health agencies within the Department of Health and Human Services. The Director of CDC also serves as the Administrator of ATSDR.

Environmental Protection Agency (EPA) – http://www.epa.gov/
The mission of the U.S. Environmental Protection Agency is to protect human health and to safeguard the natural environment--air, water, and land--upon which life depends. EPA's purpose is to ensure that:

- All Americans are protected from significant risks to human health and the environment where they live, learn, and work.

- National efforts to reduce environmental risk are based on the best available scientific information.
- Federal laws protecting human health and the environment are enforced fairly and effectively.
- Environmental protection is an integral consideration in U.S. policies concerning natural resources, human health, economic growth, energy, transportation, agriculture, industry, and international trade, and these factors are similarly considered in establishing environmental policy.
- All parts of society--communities, individuals, business, state and local governments, tribal governments--have access to accurate information sufficient to effectively participate in managing human health and environmental risks.
- Environmental protection contributes to making our communities and ecosystems diverse, sustainable and economically productive.
- The United States plays a leadership role in working with other nations to protect the global environment.

Human Resources and Services Administration (Federal-HRSA) – http://www.hrsa.gov/
The mission of HRSA is to improve the nation's health by assuring equal access to comprehensive, culturally competent, quality health care for all. Their goal is 100 percent access to health care and 0 percent access to health disparities for all Americans. The administration's vision is to assure the availability of quality health care to low income, uninsured, isolated, vulnerable and special needs populations and meets their unique health care needs. Five strategies are focused on achieving HRSA's goal, to eliminate barriers to care, eliminate health disparities, assure quality of care, and to improve public health and health care systems.

State Agencies, Departments and Divisions

Similar to federal level administrations and agencies, many state agencies influence or contribute regulations, funding, consultation and technical assistance, and/or assessment information to local health jurisdictions. Other groups and entities are important in the support and statewide coordination of public health efforts and activities. Some of these agencies and groups are described below. Many others are referenced in the Orientation Toolkit under the Public Health System knowledge area, with descriptions of their function, websites and contact information.

Department of Ecology (DOE) – http://www.ecy.gov/
The Mission of the Department of Ecology is to protect, preserve and enhance Washington's environment, and promote the wise management of our air, land and water for the benefit of current and future generations. This state agency provides funding for enforcement and technical support for solid and hazardous waste, biosolids and water well construction, water rights, air quality and community sewage disposal. The state DOE has 11 programs providing protection in air quality, water quality and resources, nuclear waste, environmental assessment, reduction of hazardous waste and toxics cleanup, shorelands and environmental assistance, solid waste and financial assistance, and spill prevention, preparedness and response.

Department of Social and Health Services (DSHS) – http://www.dshs.wa.gov/
In the late 1960s, the legislature created DSHS by combining the prior departments of health, corrections, and social services under one large state agency. There are seven administrations

within DSHS: Aging and Adult Services Administration (AASA), the Children's Administration (CA), Economic Services Administration (ESA), Health and Rehabilitative Services Administration (HRSA), Juvenile Rehabilitation Administration (JRA), Management Services Administration (MSA), and Medical Assistance Administration (MAA). Many of the divisions within DSHS work closely with local health jurisdictions, often through regional offices. For some of the programs provided by these divisions there are county components with a local presence.

Health and Rehabilitative Services Administration (HRSA) – HRSA includes six separate programs: the Division of Alcohol and Substance Abuse, the Division of Developmental Disabilities, the Office of Deaf and Hard of Hearing Services, the Mental Health Division, the Division of Vocational Rehabilitation, and the Special Commitment Center. Two of these programs are described below.

Division of Alcohol and Substance Abuse (DASA) –
http://www.dshs.wa.gov/indetail/4hrsadir.htm#dasa
The Division of Alcohol and Substance Abuse, a division of HRSA in DSHS, works in partnership with county governments, Tribes, and nonprofit agencies to provide a broad range of alcohol and drug abuse prevention, treatment and support services. People are eligible for DASA-funded treatment services if they are low income or indigent (at or below 200 percent of the federal poverty level) and are assessed as alcoholic or addicted to other drugs. There is a waiting list for many of these services. Priority for treatment and intervention services is given to pregnant and postpartum women and families with children, families on welfare, Child Protective Service referrals, youth, injection drug users, and people with HIV/AIDS. In Fiscal Year 1998, 25,402 people received publicly-funded treatment (excluding detoxification). Twenty percent were children and youth age 18 and under, two percent were pregnant women, one percent was postpartum women, 27 percent were injection drug users, 43 percent were criminal justice referrals, and 11 percent were people on welfare.

Mental Health Division of HRSA - The Mental Health Division of DSHS cares for people who are acutely mentally ill, chronically mentally ill, or seriously disturbed. The division also administers programs for people adjudicated as criminally insane or incompetent to stand trial. Over 106,000 people received outpatient services during Fiscal Year 1999. Community hospitals provided psychiatric inpatient services to 7,190 people during the 1999 calendar year. Of the total mental health budget, 58 percent is for community-based outpatient care; another 11 percent is for contracted community inpatient care. The balance of the budget funds the state hospitals. The Mental Health Division operates three fully-accredited psychiatric hospitals: Eastern State Hospital, Western State Hospital, and the Child Study and Treatment Center. The Mental Health Division also directly contracts with county governments through Regional Support Networks (called RSNs) for community mental health service delivery. Community-based inpatient psychiatric services are provided through contracts with local hospitals.

Medical Assistance Administration (MAA) – http://www.wa.gov/hca/basichealth.htm
The Medical Assistance Administration helps low-income people get the health care they need. Ninety-six percent of the people this Administration helps get their care through

Medicaid. The federal government shares the cost of this program with the state, and the federal government makes most of the policies under which the program operates. Medicaid helps older low-income adults by covering medical costs that are excluded from Medicare. And it provides health care for people in WorkFirst, Washington's welfare reform program.

Washington is the leader in coverage for children. It covers children up to 200 percent of the federal poverty level (FPL) under Medicaid and children up to 250 percent FPL through the Children's Health Insurance Program (CHIP). Some people who aren't eligible for Medicaid are covered under state-administered programs. This includes people with temporary disabilities or emergency medical needs, and children who do not have documentation of their citizenship status.

In addition, refugees and immigrants receive health care through the federal Refugee Medical Assistance Program or the State Family Assistance Program. People in Washington state who do not have health insurance through their employers may also enroll in the state's Basic Health Plan, which is administered by the Health Care Authority. For those who qualify for reduced-premium Basic Health, state funds will be used to help pay a portion of the monthly premium. This means members may pay as little as $10 per month for each enrolled adult. To qualify, applicants must live in Washington State, not be eligible for Medicare, and not be institutionalized at the time of enrollment. They must also meet Basic Health's income guidelines, unless they live in Clark, Cowlitz, Klickitat, Skamania, or Wahkiakum County, where applications are being accepted for individuals and families at all income levels. In addition, if a family qualifies for Basic Health, their children may be eligible for coverage at no additional cost through Basic Health *Plus*. This program offers children a wider range of benefits, including dental and vision care, with no premiums or copayments.

Department of Health (DOH) - http://www.doh.wa.gov/

The Department of Health is comprised of numerous divisions and offices including the Health Officer, the Office of Communications, the Office of Policy, Legislative & Constituent Relations and the Office of Public Health System Planning & Development. The Divisions of DOH include Community and Family Services, Health Systems Quality Assurance, Environmental Health, Epidemiology, Health Statistics & Public Health Laboratories, Information Resource Management, and Management Services. All of these offices and divisions report to the Secretary of Health, who is the senior administrative executive of the Department of Health. The state Health Officer is the senior clinical executive for the state and reports to the Secretary of Health.

Division of Community and Family Health – (CFH) -
http://www.doh.wa.gov/cfh/cfh.htm

The Community and Family Health Division administers programs to promote a healthy start to life, to positively influence health choices, and to prevent illness from the most common causes of disease and premature death, which include tobacco use, physical inactivity, poor nutrition, and injuries. The CFH division has three major offices that administer numerous programs. These include the Community Wellness and Prevention, Infectious Disease and Reproductive Health, and Maternal and Child Health.

CFH programs address: diabetes and cancer; family planning; health education and health promotion; HIV/AIDS prevention and client services; immunizations; infant, child and adolescent health; injury prevention; maternal health and genetics; nutrition services (WIC); oral/dental health; sexually transmitted diseases; tobacco prevention; tuberculosis; and women's health.

The Office of Community Wellness and Prevention within CFH develops and maintains programs designed to reduce preventable risk factors for chronic disease and injury, and provides food and nutritional services for vulnerable populations. Specific programs in the Office address risk factors such as tobacco and poor nutrition and specific diseases such as breast and cervical cancer, diabetes and heart disease. The Office contains three major program units: Chronic Disease Prevention and Risk Reduction, Injury Prevention and Safety, and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC)

Infectious Disease and Reproductive Health within CFH conducts five programs to protect and improve the health of people in Washington.

Family Planning and Reproductive Health helps to assure access to family planning and reproductive health services for the people of Washington State. The programs include birth control, family planning, reproductive health services such as pelvic exams, pap smear, testicular exams, and prenatal care; and sexually transmitted disease education and treatment.

HIV Client Services works to assure that persons with HIV in Washington have access to quality, culturally sensitive, comprehensive health care and supportive services. HIV Client Services supports limited medical, dental, prescription drug, case management and other social services by contract and by direct payment for low to moderate-income people living with HIV/AIDS. HIV Client Services addresses local needs by helping local consortia assess, plan and provide care programs.

HIV Prevention and Education Services works to reduce the impact and transmission of HIV in Washington State. The section provides leadership and support for effective HIV prevention planning, education and intervention services with local health jurisdictions, the regional AIDSNETs, community planning groups, community-based organizations and other state agencies. Prevention and Education Services also provides accurate information regarding HIV through its statewide HIV Hotline, review of HIV/AIDS curricula and other materials, and the production of "Washington State Responds. "

The Sexually Transmitted Disease (STD) Program is responsible for the coordination, control and prevention of STDs within the state of Washington. The program works to reduce or eliminate STDs by assisting state, local, and community efforts to ensure access to quality clinical services, develop comprehensive prevention services, and deliver culturally sensitive education for clients at highest risk of infection. Program components include surveillance, diagnostic and treatment services, partner management, laboratory screening, public and professional education, and consultation to local health jurisdictions and other health providers.

The TB Program is responsible for the coordination, control and prevention of tuberculosis within the state of Washington. The TB Program works with local health jurisdictions, health professionals and communities to assure access to TB screening, diagnosis and treatment and to ensure therapy adherence and completion. The program also implements partnerships to deliver outreach and contact follow-up on new cases; provides comprehensive culturally sensitive education for clients at highest risk of infection, and ensures the highest quality epidemiological information for policy development and program planning. Program components include surveillance, medical consultation, contact investigation, professional education, and technical assistance.

Maternal and Child Health (MCH) - Maternal and Child Health Program works to promote an environment that supports and encourages the optimal health of all women of child bearing age, infants, children, adolescents and their families.

Maternal and Child Health has four major program areas: Children with Special Health Care Needs, MCH Assessment, Child and Adolescent Health and CHILD Profile, Maternal and Infant Health, and Immunization. In addition, Maternal and Child Health has an Assessment Section, a Genetics Services Section, and the Office of the Director. The Office of the Director includes epidemiology, medical consultation, policy, planning, and administrative functions.

Division of Epidemiology, Health Statistics & Public Health Laboratories –

This division of DOH is responsible for programs in the areas of Epidemiology, the Center for Health Statistics, the Public Health Laboratories, and Administration.

Division of Environmental Health –

At the state level the division includes programs for Drinking Water, Radiation Protection, Food Safety and Shellfish, Environmental Health and Safety, and Environmental Health Assessments.

Drinking Water - At the state level, the DOH Division of Drinking Water has responsibility for overseeing a comprehensive regulatory program for all water systems subject to federal Safe Drinking Water Act (SDWA), which are defined as “Group A” water systems. Generally, these are systems that serve 15 or more connections or serve an average of 25 or more people for 60 or more days each year. DOH offers training on drinking water issues and assists in investigations of potential waterborne disease outbreaks or other health issues associated with drinking water.

Associations and Professional Organizations

National Association of County and City Health Officers (NACCHO) - ***http://www.naccho.org/about.cfm***

NACCHO was formed in July 1994 when the National Association of County Health Officials and the U.S. Conference of Local Health Officers combined to form a unified organization representing local public health. The two predecessor organizations were formed separately in the 1960s. NACCHO is a nonprofit membership organization serving all of the nearly 3,000 local health departments nationwide—in cities, counties, townships, and districts. NACCHO provides education, information, research, and technical assistance to local health departments and facilitates partnerships among local, state, and federal agencies in order to promote and strengthen public health. NACCHO is governed by a 32-member Board of Directors, comprising health officials from around the country elected by their peers, and including ad hoc members representing the National Association of Counties, of which NACCHO is an affiliate, and the U.S. Conference of Mayors. NACCHO conducts numerous activities in support of the work of local health departments:

- MAPP - Mobilizing for Action through Planning and Partnerships
- Assessment Protocol for Excellence in Public Health (APEX*PH*)

Washington State Public Health Association (WSPHA) – http://www.uspha.org

WSPHA, the Washington State affiliate of the APHA, is the primary professional organization for personal health, dental health and public health administrators. Its mission is to equip their members with the knowledge and skills to address public health challenges. The goal of the Association is to function as a comprehensive public health leadership organization in the state. Its aid is to bring together and coordinate efforts of the professional health worker, the volunteer and the lay health leader in defining and promoting public health issues. WSPHA holds the annual statewide public health conference each autumn called the joint conference on public health. This joint conference is recommended for all LHJ administrators and other state and local leaders and public health staff.

Washington State Association of Counties (WSAC) – ***http://wwwwacounties.org/wsac***

WSAC is a non-profit, non-partisan organization that represents Washington's counties before the state legislature, the state executive branch, and regulatory agencies. The majority of WSAC's funding comes from dues paid by member counties. Members are county commissioners, and while membership is voluntary, WSAC consistently maintains 100% participation from Washington's 39 counties. WSAC focuses its work in several areas: Legislative Advocacy, Membership Assistance, District and Statewide Conferences, Technical Assistance / Educational Workshops, State agency and Rule making Advocacy, and Publications. WSAC affiliates include associations for county and regional planning directors, county parks and recreation boards, county engineers and public works, WWSALPHO, and the Association of County Human Services (ACHS).

Washington State Association of Local Public Health Officials (WSALPHO) - http://www.wacounties.org/wsalpho

WSALPHO is an affiliate of Washington State Association of Counties (WSAC) and the state affiliate of NACCHO. It is the policy group for local public health issues. WSALPHO is currently comprised of public health leaders and managers from the 34 local health jurisdictions from throughout Washington State. Each LHJ may designate up to six voting members. Three subgroups, called forums, provide the mechanisms for addressing issues specific to certain disciplines within the LHJs. These forums are: the Public Health Executive Leadership Forum (PHELF) which includes the health officers and administrators, the Public Health Nursing Directors (PHND), and the Environmental Health Directors (WSEHD).

WSALPHO has established three subcommittees to coordinate activities in critical areas for local public health – the Legislative Committee, the Nominating Committee, and the Recognition and Awards Committee. The WSALPHO Board of Directors also conducts joint meetings with the DOH Senior Management Team. These quarterly meetings allow time for interchange among DOH leadership and the leadership of local health jurisdictions.

Washington Association of County Officials (WACO) -
http://www.wacounties.org/waco/main.html

In 1959 the Washington State Legislature created WACO to coordinate the administrative programs of the 39 counties and to assist in developing recommendations to the Governor and the Legislature to increase the efficiency of the county departments headed by the county officials. Seven affiliate groups of elected county officials and their appointed counterparts in charter counties comprise the membership of the Washington Association of County Officials, including county assessors, auditors, clerks, coroners, and medical examiners, prosecuting attorneys, sheriffs, and treasurers.

UW School of Public Health and Community Medicine –
http://depts.washington.edu/sphcm/
The School of Public Health and Community Medicine (SPHCM) is one of 17 schools and colleges at the University of Washington. There are five departments in the School: Biostatistics, Environmental Health, Epidemiology, Health Services, and Pathobiology. Our emphasis is on strong academic programs in the public health disciplines, represented by the departments. At the same time, there is extensive interdepartmental collaboration due to the interdisciplinary nature of our research and training programs. The combination of discipline-oriented academic programs and strong interdisciplinary research provides a setting for faculty and students to apply in-depth expertise to broad public health problems.

NW Center for Public Health Practice (NWCPHP) -
http://healthlinks.washington.edu/nwcphp/

The Northwest Center for Public Health Practice is dedicated to providing a link between public health practitioners and academia. NWCPHP, along with the School for Public Health and Community Medicine provides practice-oriented education and training programs for

practitioners in public health agencies and community-based health centers. The Center works with health agencies throughout the Northwest in developing these programs.

The Summer Institute for Public Health Practice was launched by the Northwest Center nine years ago in response to rapidly changing training needs among public health professionals in this region and beyond. Each year the Institute has continued to provide public health professionals the opportunity to learn practice-based skills that can be readily applied in their work setting.

Self-Assessment of Public Health System Knowledge

The following questions will help you assess your current proficiency and identify areas of focus for your orientation plan. Please check the appropriate response for each question in the boxes provided. The three columns reflect the three levels of proficiency, and are labeled PRO= Proficient, KNOW= Knowledgeable, and AWARE.

WASHINGTON STATE PUBLIC HEALTH SYSTEM	**PRO**	**KNOW**	**AWARE**
Have you ever worked in public health?	☐	☐	☐
in Washington State?	☐	☐	☐
Have you worked with the State Department of Health in the past?	☐	☐	☐
Have you worked with the State Department of Social and Health Services in the past?	☐	☐	☐
Do you understand the role of public health and the LHJ in the community?	☐	☐	☐
Are you familiar with the relationships and functions of DOH, DSHS, and other state agencies?	☐	☐	☐
Are you familiar with the Washington State Association of Local Public Health Officials (WSALPHO) and with NACCHO?	☐	☐	☐
Do you understand the core functions and the 10 Essential Public Health Services?	☐	☐	☐
Are you familiar with the Public Health Improvement Plan, including the Standards for Public Health Performance?	☐	☐	☐
Are you a member of the Washington State Public Health Association and/or the American Public Health Association?	☐	☐	☐
Do you feel you need further orientation to basic public health practice to adequately perform your duties as public health administrator?	☐	☐	☐

Please list other areas needing further orientation, if any:

Tab 2

Boards of Health and Legal Authority for Public Health

Boards of Health and Legal Authority for Public Health

Local health jurisdictions in Washington State are governed by both local and state regulations. The hierarchy of rule making authority is as follows:

- The Washington State Legislature has the primary legislative authority for public health, developing the Revised Code of Washington. Usually RCWs provide general intent, assigning detail to a department of state government or another governmental body.

- A department (Health, Agriculture, Ecology) of state government is granted authority by the Legislature through the RCW to develop administrative rules or chapters of the Washington Administrative Code.

- The Washington State Constitution established the Washington State Board of Health (SBOH) with authority to develop Washington Administrative Code. The SBOH has developed rules for the authority and legislative RCWs governing the operations of public health programs.

- A local board of health is granted authority by the Legislature through the RCW to develop local rules and regulations and to develop fees to carry out those rules. The local Boards of Health function separately from the SBOH and will often supplement SBOH rules to address local problems. Local board of health rules cannot be less stringent than SBOH rule.

- A city is granted authority by the Legislature through the RCW to develop local ordinances. Cities often have local ordinances governing garbage handling, keeping of livestock, development of wells within the city limits and noise control which they may request the local health jurisdiction to enforce. See Tab 3 “Local Health Jurisdictions” for more information.

The Revised Code of Washington (RCW) – http://www.leg.wa.gov/wsladm//rcw.htm

The specific RCWs that provide legal authority for the State and Local Boards of Health are listed in the table below.

RCW	Title	Purpose
43.20	State Board of Health	Membership, authority and responsibilities
43.20.050	Powers and duties of State Board of Health	Authority to develop rules for prevention and control of infectious disease, drinking water, environmental conditions including food service, schools, camps and spas
70.05.060(3)	Local Board of Health	Authority for local board of health to adopt rules
70.05.060(5)		Authority for local board of health to declare emergency
70.05.060(7)		Authority of local board of health to establish fees

State Board of Health – Composition and Function
http://www.doh.wa.gov/SBOH/default.htm

The Washington State Board of Health is a ten-member board appointed by the Governor to develop policies to promote, protect, maintain, and improve the health of Washingtonians. The board consists of one elected county official and one elected city official who are members of local health boards, four people experienced in matters of health and sanitation, two people representing consumers of health care, a local health officer, and the State Secretary of Health (or designee). The board solicits information about health concerns by holding monthly meetings, sponsoring public forums, and conducting citizen surveys. It also works with interested parties to develop and assess rules and regulations based on health-related legislation and Board policy that often govern operations at the state Department of Health and within local health jurisdictions. The Board responds to citizen inquiries and requests for deviation from regulations or policies through waivers and exemptions, rule development, and rule revision.

Local Boards of Health – Composition and Function

A local board of health oversees public health in a local jurisdiction. Title 70 RCW places primary responsibility for public health activities with local governments, giving them broad responsibilities for protecting the public health through program design and delivery, rule making authority, enforcement and control powers, reporting requirements, and establishing fee schedules for licenses or permits or other services.

For single county health departments the local board of health has the same membership as the governing body of the county that it serves. For combined city-county health districts, RCW 70.46.030 defines the membership of the local board of health and states that it must represent the county that comprises the district. Recent legislation has allowed community citizens to serve as board members, in addition to elected county officials, in some counties.

For multi-county health districts RCW 70.46.020 stipulates that the local board membership must represent the counties that comprise the district. The members must be from the governing bodies of the counties by mutual agreement of those governing bodies.

Key Relationships

The LHJ Administrator must communicate and interact with numerous public and private entities, with commissioners, staff, community members, and volunteers. The table below describes some of the key relationships related to the regulatory and governance arena of public health.

ENTITY	FUNCTION
Legislature	Establishes general policy for local government programs, delegates rule making to State Board of Health, requires input on suitability of policy making decisions
State Board of Health	Establishes rules for most local health jurisdiction programs, has DOH and local board of health member, requires input on suitability of policy making decisions

ENTITY	FUNCTION
Local Board of Health	Financial and policy making group, hires Director or Administrator of Public Health, establishes local portion of budget
County Commissioners	May serve on local board of health or other community boards, assists in policy and funding decisions for LHJ programs
County Administrator	interface with Board of Commissioners
Local Municipal Government	Establishes city or local regulations and codes
Local Prosecutor	Reviews new/revised rules, counsels Board of Commissioners and health department, may defend staff in event of lawsuit; in a health district a private attorney is required

Other Suggestions for Community Members of Importance to New Public Health Administrators

Mayor(s), Chamber of Commerce members, newspaper editor(s), hospital administrators, area clinic administrators, local medical association president and members, other key physicians, tribal leaders and staff from tribal health care facilities, leadership of various institutions (e.g., schools, prisons/jails, nursing homes)

Self-Assessment of Boards of Health and Legal Authority for Public Health

The following questions will help you assess your current proficiency and identify areas of focus for your orientation plan. Please check the appropriate response for each question in the boxes provided. The three columns reflect the three levels of proficiency, and are labeled PRO= Proficient, KNOW= Knowledgeable, and AWARE.

BOARDS OF HEALTH AND LEGAL AUTHORITY OF PUBLIC HEALTH	**PRO**	**KNOW**	**AWARE**
Do you know the legal basis for public health authority and the legal authority for Boards of Health?	☐	☐	☐
Do you know the differing roles of public health and of the Boards of Health?	☐	☐	☐
Do you know how to access the full text of Washington State laws including the Revised Code of Washington and Washington Administrative Code?	☐	☐	☐
Have you participated in local Board of Health meetings? Do you understand the administrator role in these meetings?	☐	☐	☐
Have you participated in or conducted a Board of Health development or orientation process?	☐	☐	☐
Do you know the appropriate process to use in addressing a public health issue with the local Board of Health?	☐	☐	☐
Do you know who the county attorney is and the protocol for interacting with him/her?	☐	☐	☐
Do you feel you need additional orientation or training in legal authority of public health to adequately perform your duties as public health administrator?	☐	☐	☐
Do you feel you need additional orientation or training in legal authority of Boards of Health to adequately perform your duties as public health administrator?	☐	☐	☐

Please list other areas needing further orientation, if any:

Tab 3

Organizational Structures in

Local Health Jurisdictions

Public Health Infrastructure

The Washington Public Health infrastructure reflects the concept of "a governmental presence at the local level" which is responsible for the health of the community. This concept is based on a multi-faceted, multi-level governmental responsibility for assuring that the public health needs of the community are met. It is a responsibility that often involves other agencies in addition to the public health agency at any particular level.

The establishment of local health jurisdictions in Washington State spans ninety years. In 1911 Yakima County established the first health department in Washington State, ostensibly to combat a Typhoid Fever outbreak. Klickitat County, the 34th and newest local health jurisdiction in the state was established in 1998 in an effort to provide better services to the community. The legislative authority for local health jurisdictions is summarized in the following table.

Legislative Authority for Local Health Jurisdictions - http://www.leg.wa.gov/wsladm//rcw.htm
Or http://slc.leg.wa.gov/wacbytitle.htm

RCW	WAC	Title	Purpose
70.05		*Local Health Jurisdictions*	
70.05.040		Local Boards of Health – Administrative Officer	Authority to appoint Administrative Officer
70.05.070			Authority of local health officer
70.05.070			Authority for local health officer to declare an emergency
70.08		City-County Health Departments	Authority to form Combined City-County Health Departments
70.46		Health Districts	Authority to establish Multi-County Health Districts
		Program Specific RCWs and WACs	
43.20.050	246-100	Communicable And Certain Other Diseases	Establishes a list of reportable conditions as well as timelines and procedures for follow-up
43.20.050	246-203	General Sanitation	Establishes rules for burial of dead animals and other sanitation concerns
43.20.050	246-215	Food Service	Establishes inspection frequency and performance standards for food service establishments
43.20.050	246-272	On-Site Sewage Systems	Establishes statewide rules for managing on-site sewage
43.20.050	246-280	Recreational Shellfish Beaches	Establishes standards for evaluating water quality at recreational shellfish harvesting beaches
43.20.050	246-290	Public Water Supplies	Requirements for persons operating a public water supply
43.20.050	246-291	Group B Public Water Systems	Requirements for persons operating small public water systems
43.20.050	246-293	Water System Coordination Act	Requires public water systems to establish service areas and coordinate service
43.20.050	246-366	Primary And Secondary Schools	Requirements for environmental conditions in schools and playgrounds

Legislative Authority For Local Health Jurisdictions, cont'd

RCW	WAC	Title	Purpose
43.21A.080 91.11.090	173-312	Coordinated Prevention Grant	Provides guidance and funding to local health for enforcing solid waste regulations
59.18		Residential Landlord-Tenant Act	Requires local health jurisdiction to respond to complaints
64.44	246-205	Decontamination of Illegal Drug Sites	Requires local health agency to post warnings and supervise clean-up of contaminated properties
70.54.010		Polluting Water Supply	Authority to act when well, spring, stream, river or lake used for drinking water source is being polluted
70.54.020		Furnishing Impure Water	Authority to act when landlord is furnishing impure water
70.90.120 43.20.050	246-260	Water Recreation Facilities	Establishes authority for permitting water recreation facilities
70.94		Washington Clean Air Act	Establishes authority for air pollution program and authorities

Health Departments, Districts, and Multi-County Districts – Definitions and Implications

Washington has 34 local health jurisdictions that are entities of local government. They are not satellite offices of the State Department of Health or the State Board of Health. Every county must either form a local health department or district, or be a part of a health department with other local health jurisdictions (RCW 70.05).

Health Departments

There are 20 local health departments. These include both single county departments and two combined city-county departments. (RCW 70.08 states that cities with a population of over 100,000 may combine with their county to form a health department.) The governing bodies of the city and county establish and operate a combined city/county department and appoint a director or administrator of public health. In single county health jurisdictions, the Board of County Commissioners constitutes the local board of health. In many small and medium size counties health departments include both health and a variety of human services programs.

Health Districts

Health District is defined in RCW 70.05.010 as "all the territory consisting of one or more counties organized pursuant to the provisions of chapters 70.05 and 70.06." There are 10 health districts that operate as political subdivisions separate from other offices of county government. RCW 70.46.020 through 70.46.090 describe the formation of health districts and the local board of health composition for health districts. Health district local boards of health must include a minimum of five members with at least three of those members from the county legislative authority.

Multi-County Health Districts

In the late 1960s and early 1970s local governments and the Health Services Division of DSHS began efforts to combine less populous health departments into multi-county health districts. The purpose of multi-county health districts was to reduce administrative costs, increase technical expertise, and provide a broader base of services to the district's residents. Currently, there are four multi-county districts – the Northeast Tri-County that includes Pend Oreille, Stevens, and Ferry counties; the Benton-Franklin Health District, the Southwest Washington Health District, which includes Clark and Skamania counties, and the Chelan-Douglas Health District.

Key Relationships

Establishing and maintaining internal and external relationships is key to successful public health programs in a local health jurisdiction. A listing of some key relationships follows:

ENTITY	FUNCTION
Local Health Officer	RCW mandates local health officer; may be part-time in some local health jurisdictions
Personal Health Director	Manages programs and staff related to personal health services such as immunizations, WIC, maternity and prenatal care
Environmental Health Director	Conduct routine EH program activities
Auditor	Tracks all department expenditures, compiles county budget
Emergency Management	Coordinates all county, state and tribal functions during major emergency
Social or Human Services Manager/Director	Administers county-based programs addressing mental illness, and chemical dependency treatment and prevention services, and developmental disabilities
Information Services (Data Processing)	Maintains phone and computer system, may be responsible for developing databases
Planning Department	Coordinates land use, chairs Land Use Team
Public Works Department	Is part of land use team, may operate solid waste facilities, technical support for drainage
Solid Waste Department	May manage solid waste facilities, recycling facilities, Coordinated Prevention Grant
Community Services Office (CSO) Administrator	Local contact to coordinate any DSHS programs administered through the local Community Services Office – e.g. Medicaid, CSO Family Planning Services
DSHS/DCFS Supervisor	Interfaces with the DSHS PASSPORT and early intervention (EIP) programs and is the local contact for any Child Protective Services (CPS) issues
RSN Administrator	Responsible for managing a local mental health system. May be multi-county or single-county based
Hospital Administrator	Linkage for coordinating services, and community planning and priority setting activities
Community Clinic (Medicaid)	Linkage for coordinating services
Sheriff	Linkage to coordinate emergency response plans and response to environmental outbreaks
Newspaper Editor or health reporter	Link to media and distribution of critical public health messages. Can assist in highlighting public health events and news items.

Key Local Health Jurisdiction Functions and Programs

The 2000 Public Health Improvement Plan describes the core functions of Public Health as Assessment, Policy Development, and Assurance. Most health departments are not organized along these lines, although some have attempted to do so. Traditionally public health departments in Washington have been divided between Personal Health Services, Environmental Health Services and Administration. While this administrative structure still survives it varies significantly from jurisdiction to jurisdiction. Many jurisdictions have separate assessment divisions, or health education units that cross these traditional boundaries. In addition, the level of clinical services provided by jurisdictions can range from complete primary care to virtually none at all.

Direct provision of services or assurance of service provision:

One of the three core functions of public health is to assure that needed services are provided to the public. Traditionally this resulted in local health departments delivering the needed care directly to the community. In the last decade, due to legislative changes and funding reductions, this function has changed from providing the services directly to assuring that other practitioners and organizations in the community are delivering the services. The adoption of the Health Services Act of 1993 (Health Care Reform) increased the transition of service delivery out of local public health to the private sector. The 1995 Legislature repealed Health Care Reform without providing adequate alternative funding for LHJs to assure the quality of care and service by private providers. This left many local PH health officers and administrators wondering how to evaluate the pros and cons of transitioning services to the private sector.

In deciding whether or not to transition services there are general questions and issues that should be considered:

- Is the service available in the community and if so, how much access is there to the service?
- What is the quality of the care and service that is available in the community?
- Is continuity of care an issue to be considered?
- Would convenience of care be a barrier to some clients; for example, clients with transportation constraints who need immunizations, WIC services, family planning services, and maternity support services?
- Is confidentiality of care an issue to be considered?
- Will the cost of care and the client's ability to pay, or the lack thereof, be a constraint to getting needed care?

In specifically responding to the loss of funding through I-695 or other legislative or regulatory changes, five models have been used to assist LHJ leadership in applying specific criteria for making a transition of services decision.

Mission/Risk Driven model: The LHJ may rethink their core mission and business, and focus on the high risk populations. In this model the ability of someone else in the community provide the service should be considered. The LHJ can also support recruitment of a new Community Health Center to the community.

Funding and Mandate Driven Model: Health department programs are reviewed and ranked (from highest to lowest priority to maintain) according to the following criteria. Cuts are focused on programs that duplicated effort of others in the community (e.g. parenting classes) and ranked lowest priority.

Criteria:

1. Funded and mandated (highest priority)
2. Not funded, mandated
3. Funded, not mandated
4. Not funded, not mandated (lowest priority)

Program Driven Model: Health department programs were reviewed and evaluated according to the following questions:

- Is there a need for a government role?
- Degree of primary prevention?
- Degree of direct public benefit?
- How effective is the program?
- Benefit related to cost?
- Severity of condition prevented?
- Degree of political support?

*Performance Standards Driven Model: T*he Public Health Performance Standards are used as a guide and programs are evaluated according to the following criteria:

- Does it address a public health problem?
- Is it consistent with LHJ responsibility and authority?
- Are there interventions that work?
- What is the budget impact?
- Also used Proposed Performance Standards as a guide.

Zero Based Budgeting Model: The LHJ uses zero based budgeting to fund future programs, thereby eliminating programs that are not funded, regardless of the risk levels or unfunded needs of the community.

Personal Health Services - These services relate to clinical services, general services and primary care for families. Most LHJs have many of these personal health services.

Family Planning and Reproductive Health (FPRH) -

FPRH works to reduce the health and social impacts of unintended pregnancy by helping men and women choose the timing and spacing of their pregnancies. Program components include developing and sustaining support for family planning providers, enhancing local capacity to provide services, and collaborating with other programs to integrate and expand family planning and reproductive health services and information. Services for FPRH are funded through the state division that contracts with local non-profit agencies, local health jurisdictions, and community consortia. FPRH provides federal Title X and State family planning funding for comprehensive family planning services in 31 of the state's 39 counties. The target populations for FPRH services are

women and men in need of subsidized services without access to other providers, and adolescents, regardless of income.

Maternal and Child Health Services - This program includes services related to the health and well-being of pregnant women, mothers, infants, children and adolescents. The prenatal, antepartum, and postpartum periods and any follow-up care related to pregnancy or delivery is included. The services include nursing assessment, diagnosis, and intervention; primary, secondary and tertiary levels of preventive services for infants, children, and adolescents in various settings; and leadership activities for development of community-wide services. Revenues received from Medicaid (Title XIX) for women's and children's services should assist with funding for these programs.

Children with Special Health Care Needs (CSHCN)- Provides resources and funding to link, coordinate, and pay for comprehensive services for infants and children from birth to 18 years of age with or at risk for special health and/or developmental needs. Primary focus of services is care management to develop coordinated systems of care for these infants, children and their families.

Maternal and Infant Health - These programs optimize healthy outcomes by improving health and support services for pregnant and post-partum women, their infants and children. They accomplish this by assuring access to services, training, education, assessment and intervention, as well as a system of regional perinatal care that includes the availability of quality tertiary care for high risk women and newborns. Services are provided by a collaborative network consisting of state, local health jurisdiction and non-profit providers, and include confidential pregnancy testing and referral, maternity support services, and early prenatal, child development and parenting information and education.

Child and Adolescent Health and CHILD Profile
These programs work to promote and protect the health and well-being of children, adolescents (including pregnant and parenting teens) and their families through assurance of integrated primary care and preventive clinical, oral and nutritional services. Services promoted by these programs include well child and adolescent screening and referral, child abuse and neglect prevention, teen pregnancy prevention programs including a statewide public relations and media campaign, nutrition consultation, child death review development, and population based oral health screening and sealant programs.

Immunization
This program protects residents against vaccine preventable diseases through a statewide immunization delivery system. Services include distribution of no cost vaccines to local health departments, support to local communities for projects targeting "hard to reach children" and technical assistance during disease outbreaks.

Women, Infants and Children (WIC) - is a preventive health program designed to influence positive, lifetime nutrition and health behaviors. WIC provides pregnant and breast feeding women and children from birth up to age five with nutrition education, breast feeding support, health referrals, and checks to purchase nutritious food in community grocery stores. WIC reaches over 265,000 women and children each year. Nearly half of all babies born in Washington benefit from WIC. To be eligible families

meet the WIC income guidelines. Families receiving TANF, Food Stamps, Medicaid or Healthy Options are automatically income eligible. WIC also provides nutrition screening to help determine eligibility.

Communicable Disease Services – The state and local levels collaborate in disease reporting and contact information, disease investigation, and disease surveillance activities to control and prevent communicable diseases. These services provided at the local level can include the immunization program and education and services for diagnosis, treatment and control of sexually transmitted diseases, tuberculosis, AIDS, and other communicable diseases.

Environmental Health Programs

Environmental Health Education - Education is a primary and vital part of the public health system. Because of the limited exposure between the client (often an industry such as a food establishment) and the environmental health specialist, it is important that the message that is presented is understandable and beneficial. This program is often integrated into any of the other environmental health programs without special designation as a separate activity. Some LHJs utilize the expertise of public health educators to aid the technical environmental health staff with the production of educational materials such as brochures, pamphlets, videos, and other media.

Drinking Water Program - The purpose of the Drinking Water Program is to protect drinking water from disease organisms or chemical contaminants that may affect the health of the consumer. Funding is primarily through permit fees, local dollars, and Department of Ecology pass-through fees and initial grants. Local health jurisdictions and local health officers have independent authority under RCW 43.20.050, 70.05 and Chapters 246-290, 246-291, and 173-160 WAC to oversee the safety of drinking water and public water systems. Generally the water program works under a joint plan of operation (JPO) negotiated with DOH. Under the JPO, local health jurisdictions usually agree to regulate small public water systems defined as "Group B Water Supplies."

Solid Waste Program - The purpose of the solid waste program is to control the disposal of solid waste materials that may affect the health of the people in the community. These effects may include chemical contamination of the ground water that serve as drinking water sources. The local health officer is delegated his/her authority by Chapter 70.95 RCW and Chapter 173-304 WAC to enforce regulatory requirements for the management and handling of solid wastes. The permitting and inspection of solid waste facilities and the investigation of unlicensed sites for compliance, usually resulting from solid waste complaints, are the primary tools of enforcement for the protection of public health and the environment. Fees for annually permitted facilities and a solid waste enforcement grant from the Washington State Department of Ecology fund the solid waste program.

Liquid Waste Program - The purpose of the Liquid Waste Program is the protection of the health of the people in the community from chemical and disease organisms originating from the disposal of human sewage. The program focuses on the protection of ground and surface water from contamination and the prevention of human access to contaminants through proper handling and disposal. The funding is primarily through permit fees, Department of Ecology educational grants, and local dollars. Liquid waste is

a demand program, especially during the normal construction season. Local health officers are responsible for all on-site sewage systems that serve structures generating daily wastewater flows of 3,500 gallons or less at a common point (e.g. building drain). A high degree of interaction with other county agencies is required. The Department of Licensing must certify inspectors who work in this program. Persons who design on-site sewage systems must be licensed as designers by the state.

Food Program - The purpose of food programs is to prevent the spread of food borne disease in the community. Most environmental health programs conduct a food program to assure sanitary standards in food service operations to prevent disease and chemical exposure under WAC Chapter 246-215. Each permitted food service establishment must be inspected at least once per year, and establishments with a higher risk (termed complex menu facilities) are to be inspected at least twice per year. Education is a major component of the food program. The staff are expected to incorporate education in their routine inspections and distribute educational handouts during inspections. Educational presentations are offered to food establishments, schools, and community groups. Most LHJs respond to complaints of food-borne illness outbreaks and work with the LHJ personal health staff to conduct investigations of the outbreaks.

Schools - Chapter 246-366 WAC gives the local health officers authority over public, private, or parochial kindergarten through twelfth grade schools. This allows for health and safety inspections in these schools as well as review of school construction plans, pre-occupancy inspections, response to complaints, and consultation on a variety of issues, ranging from indoor air quality to playground equipment. The Public Health Improvement Plan lists playground injuries as a key public health problem, citing as many as 50,000 school playground injuries in Washington State every year.

Health Education and Health Promotion Programs

Injury Prevention and Safety Program - Injuries are the leading cause of death and disability for the people of Washington ages 1-44, and remain a significant cause of death and disability throughout the life span. Injuries do not occur at random; they occur in highly predictable patterns. The Injury Prevention and Safety Program provides data and special reports to identify priority issues, and conducts activities aimed at reducing injuries.

Heart Health Program - The Heart Health program addresses cardiovascular disease prevention and control through the modification of risk factors. The program provides client education materials and technical assistance to health care providers related to high blood pressure, high blood cholesterol, tobacco use and physical activity.

Breast and Cervical Health Program - Washington State's Breast and Cervical Health Program provides free breast and cervical cancer screening and diagnostic services to women ages 40 to 64, whose income is at or below 200 percent of the Federal Poverty Level, and reimburses participating medical providers for these services. The program's mission is to provide community education and services that reduce breast and cervical cancer incidence and death in Washington State. http://www.fhcrc.org/cipr/bchp/

Tobacco Prevention and Control Program - The Tobacco Prevention and Control Program is dedicated to improving the health and saving the lives of Washington residents by reducing tobacco use. The program supports community-based and school-based programs, conducts a statewide anti-tobacco media campaign, provides a 1-800 information and referral line for adults who are thinking of quitting smoking, and educates retailers to prevent tobacco sales to minors. Additionally, the program collects data to support ongoing evaluation of program effectiveness and monitors the status of tobacco use across the state. The Washington Tobacco Quit Line number is 1-877-270-STOP.
http://www.doh.wa.gov/Tobacco/default.htm/

Self-Assessment of Organizational Structures of Local Health Jurisdictions

The following questions will help you assess your current proficiency and identify areas of focus for your orientation plan. Please check the appropriate response for each question in the boxes provided. The three columns reflect the three levels of proficiency, and are labeled PRO= Proficient, KNOW= Knowledgeable, and AWARE.

ORGANIZATIONAL STRUCTURES OF LHJs	PRO	KNOW	AWARE
Have you worked in this local health jurisdiction before?	☐	☐	☐
Are you familiar with the three types of LHJ structures – departments, districts, and multi-county districts – and the implications for LHJ operations?	☐	☐	☐
Are you aware of the considerations for having a key function such as environmental health outside of the LHJ?	☐	☐	☐
Are you familiar with the organizational structure of the local health jurisdiction?	☐	☐	☐
Are you acquainted with senior management and program leads in the local health jurisdiction?	☐	☐	☐
Have you ever participated in an infectious disease outbreak investigation?	☐	☐	☐
If you have oversight of personal health services, have you had experience with personal health services?	☐	☐	☐
Maternal and Child Health Services?	☐	☐	☐
Communicable Disease, STD ands Family Planning services?	☐	☐	☐
Children with Special Health Care Needs?	☐	☐	☐
If you have oversight for environmental health, have you had experience with Environmental Health Services?	☐	☐	☐
Have you ever participated in a food borne or water borne disease outbreak investigation?	☐	☐	☐
Are you responsible for overseeing the local health assessment unit?	☐	☐	☐
Have you ever participated in a community health assessment process?	☐	☐	☐
Are you familiar with the major health problems in the community and high priority public health activities, including demographic information and community health status data?	☐	☐	☐
Do you feel you need further orientation to any of the areas described above to adequately perform your duties as public health administrator?	☐	☐	☐

Please list other areas needing further orientation, if any:

Tab 4

Funding Sources, Contracts, and Reports

Funding Sources, Contracts, and Reports

Local Health Jurisdictions have essentially two revenue sources: general fund (general tax sources) and licenses, permits and fees to support public health functions. Each county is financially responsible for the cost of public health activities in its respective jurisdiction. The Board of Health for each jurisdiction determines the portion of financial responsibility of each local government.

State Funding of Local Public Health

The local health jurisdictions receive funding from the state through several different agencies and numerous contracts. Some of the funding is considered categorical, which means that its use is specified for a specific program or service. Categorical funds cannot be used to fund any other LHJ services. Non-categorical funds are for any appropriate use identified by the LHJ, its local Board of Health, and any relevant community groups. Below is a summary of some of the major types and sources of state funding for LHJs.

Local Capacity Development Funds

Local Capacity Development Funding (LCDF) is funding provided biennially by the Washington State Legislature to be used by local health jurisdictions to address public health issues, concerns or priorities in their respective jurisdiction. The genesis of this funding occurred in 1993 when the Legislature appropriated $10 million to be distributed to local health jurisdictions throughout Washington State. That appropriation was termed "Urgent Needs" and represented a new approach to providing state funds for public health. The funding was not tied to any specific categories of services, but rather was to provide local health jurisdictions with the flexibility to spend funds in a way they felt would best address issues, problems or priorities specific to their jurisdiction. Over the next few biennia the amount of this funding increased to over $14 million for the 1999-2001 biennium. These funds are distributed, generally speaking, on a per capita basis, with the stipulation that no jurisdiction receives less than a threshold that was established in 1995. They are allocated via the Consolidated Contract.

Motor Vehicle Excise Tax (MVET) -

A secondary provision of the Health Services Act of 1993 was the Legislature's decision to remove cities from ongoing funding of local public health departments. The Legislature accomplished this action by assigning 3.4% of the cities Motor Vehicle Excise Tax (MVET) to local health jurisdictions. The MVET, the annual MV licensing fee, was based on a percentage of the vehicle's value. It was anticipated MVET dollars would increase as the value of vehicles increased.

The Health Services Act of 1993 was repealed by the 1995 Legislature, essentially stopping the systematic increases of state funds for funding local public health. However, LCDF at the 1993 base rate plus subsequent increases continue to come to local health jurisdictions via the Consolidated Contract.

Initiative 695

The voters of Washington State voted in 1999 to reduce the MVF to a flat $30. This action immediately affected local health MVET dollars. A provision of I-695 mandated

government officials to put all fee increases to a vote of the public. The intent of I-695 was to reduce the MVET and not allow local and state government to compensate for the MVET loss by charging additional fees. I-695 was challenged in court and found to be unconstitutional. The $30 tab fee has been continued as part of separate legislation from the 2000 legislative session. Local environmental health program managers in many jurisdictions were requested to increase fees to cover 100 % of the cost of programs.

Initiative 695 Replacement Funds

The 2000 Legislature acted to replace a portion of the funds lost through I-695. The Legislature allocated moneys from the state's "Rainy Day Account" to replace 90% of the dollars that public health would have received from MVET. A joint effort between Washington State Association of Local Public Health Officials, the Washington State Legislature, Washington Association of Counties and Washington Association of Cities is underway to address long term state funding.

A Per Capita Analysis of Funding in LHJs - The following analysis on local funding is taken from the 2000 PHIP Finance Committee Report.

Why Per Capita? Per capita funding measures are valuable to control for population size and overall funding level, but other measures, such as dollars per $1,000 Assessed Value (AV), or dollars in Child/Family Health per person on Medicaid, may better explain and describe the funding pattern.

Per Capita Funding. The average local funding in public health is $22.05 per capita and $36.37 per capita when all sources of funding (federal, state and local) are considered. Among jurisdictions and across all public health standards, overall, annual per capita amounts range from $20.24 to $73.75. Other per capita measures are shown below.

Standard	Range of Local Per Capita Investment	Average of Local Statewide Per Capita Investment	Statewide Average, All Local Funds Per Capita Investment
Assuring A Healthy Environment	$2.63 to $26.35	$8.06	$9.14
Protecting People From Disease	$1.33 to $11.42	$4.02	$6.84
Understanding Health Issues	$0.14 to $9.78	$1.08	$1.91
Prevention & Community Health – Chronic Disease Prevention	$0.01 to $2.67	$0.31	$0.99
Prevention & Community Health - Family And Social Health	$0.05 to $12.09	$3.09	$10.12
Access To Health Services	$0.01 to $12.78	$1.78	$2.90
Across All Standards	$0.03 to $15.74	$3.70	$4.47
Total		$22.05	$36.37

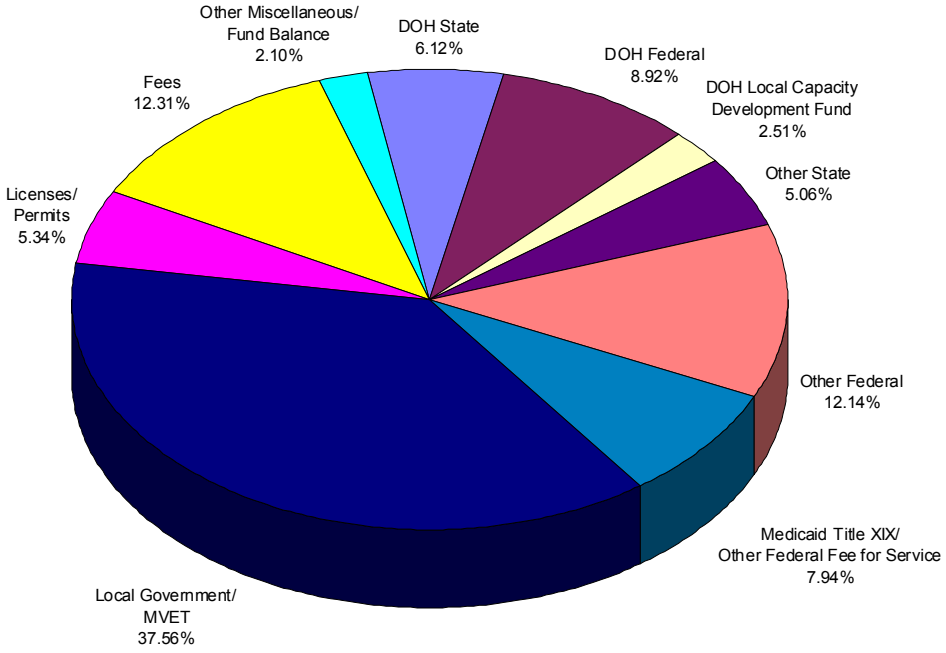
Regional Disparity. There is a difference in per capita dollars between rural and urban LHJs ($19.29 in 26 rural jurisdictions and $21.29 in 8 urban LHJs). Further, the average per capita varies by region of the state ($24.60 in the East, $23.90 in the West, $15.96 in the Central region and $22.16 in the Puget Sound area).

Fee Support. The average per capita funding varies by LHJ depending on the total amount of the budget supported by fees, as shown below.

Avg per capita with low fee support (less than 20%)	$24.25
Avg per capita with fees=20-40% of total	$21.31
Avg per capita with fees=40-50% of total	$19.04
Avg per capita with high fee support (greater than 50% of total)	$17.35

Local Fees. Fees are another local revenue source that supports public health. There is wide variation in local fees in terms of fee level, market area to support fees, local philosophy underlying cost recovery, and whether any fees will be charged for certain services. Local reliance on fees ranges from 5% to 66% of LHJ budgets.

Local Health Jurisdiction Funding Sources



The pie chart above indicates the portion of revenue at the local level from the various funding sources. (1998 BARS report summary)

Budgeting, Accounting, and Reporting System (BARS) –

http://www.doh.wa.gov/msd/OFS/

Under RCW 43.09.200, the State Auditor's Office (SAO) has prescribed the use of a uniform chart of accounts and procedures for Category I and II governmental entities that is consistent with generally accepted accounting principles (GAAP). Public Health is recorded as the expenditure category of 562.00 with the statement: *"The department or agencies actually performing these services will use the detailed chart of accounts in the appropriate BARS support system available from the state agency responsible for the program."* The Department of Health is the central point to gather information for public health related programs. It is DOH's desire to be able to consolidate information from all 34 local health jurisdictions for preparation of accurate reports that will reflect statewide program activities and funding sources. BARS data, which can report LHJ expenditures on public health, has shortcomings in showing the full universe of investment in public health since it does not capture environmental health in some cases, community providers' (non-profit and private) funding in most cases, and other numerous reporting inconsistencies.

Consolidated Contract Funding - ***www.doh.wa.gov***

The Consolidated Contract is the mechanism through which the 34 LHJs apply for and contract with the Washington State Department of Health to receive various state and federal funds that support local public health services. The contract includes funding for personal and environmental health programs such as maternal and child health, oral health, family planning and reproductive health, tobacco use prevention and control, local capacity development, HIV-AIDS prevention, and shellfish biotoxin monitoring, education and outreach.

The Consolidated Contract (known as Con Con) was developed in the early 1980's in order to simplify and centralize the process of contracting between LHJs and DOH for different program services. Using this approach, the Con Con has created a more integrated and consistent process for planning, allocation of resources, and monitoring contract activities.

The Con Con is based on a twelve month calendar year; however, plans are being made to expand to a twenty-four month contract by combining the 2001 and 2002 contract periods.

Funds are allocated to LHJs based on DOH program funding formulas. DOH program staff negotiate with LHJs to determine how the program funds will be spent. DOH staff usually meets annually with LHJs to discuss relevant program changes that are reflected in the Con Con. Any funding and program changes are reflected in contract amendments, which are completed at least every three months by the Office of Consolidated Contract staff. LHJs are reimbursed for their contract activities by submitting a monthly billing (A-19 voucher) to the DOH Office of Consolidated Contract.

DOH program staff are required to conduct a six-month and twelve-month "check-in" with each LHJ in order to assure the Office of Consolidated Contract staff that contract requirements have been met. LHJs can view and receive their Consolidated Contract materials electronically by using the Consolidated Contract web page Con Con information and regular updates can be found on the Consolidated Contract web page via the DOH web site at: http://www.doh.wa.gov

Comments, questions, and suggestions about any aspect of the Consolidated Contract can be sent to Con Con staff via email at concon.mail@doh.wa.gov.

Funding through Other Contracts

LHJs have contracts with other state agencies for selected programs. For instance, DSHS contracts with some LHJs for the Foster Care Passport program, for the Alternative Response System, and for the WORKFIRST program. Medical Assistance Administration (MAA) and the Medicaid Matching program provide funding for direct services, such as Maternity Support Services, maternity case management, and some STD and TB control services.

Funding Sources for Personal Health Services

Many of the LHJ personal health services are funded through the Consolidated Contract described above. Funding for two programs is described in more detail below as examples of the flow of federal and state dollars to LHJs.

Maternal Health Services program is funded primarily by the Title V Maternal and Child Health Block Grant and by state general funds. The federal Title V Maternal and Child Health Block Grant, authorized in 1935 under Title V of the Social Security Act, provides funds to states to develop community-based, family-centered systems of preventive, primary and specialized care which coordinate and integrate public and private resources. It is the only federally authorized program to focus exclusively on maternal and child health, and is especially directed towards low-income families, families with limited access to care and families with children with special health care needs. This block grant is population-based, in that it addresses the health of all women and children, not just targeted subgroups (e.g., a particular socio-economic or ethnic group).

Breast and Cervical Health program – This program is funded through categorical funding from the CDC, and some DOH and local funding. Tobacco Prevention and Cessation program funding is through the Con Con and from funding through the CDC.

Funding Sources for Environmental Health

The legislature, through RCW 70.05.060 (7), granted authority to local boards of health to set fees, provided the fees do not exceed the cost of providing the service. Loss of the Public Health milage in the late 1970's caused local health jurisdictions to substantially increase environmental health fees. Land use (on-site sewage and review of subdivisions), food establishment, temporary food service, swimming pools/spas, camps, camping vehicle parks and permits for installers/designers of on-site sewage systems make up the bulk of environmental health fees. Local health jurisdictions with direction from their communities and boards of health charged from 25 % to 100% of the cost of providing services. Local public health jurisdiction environmental health programs remain funded at the high levels initiated prior to adoption of I-695.

Self-Assessment of Funding Sources, Contracts, and Reports

The following questions will help you assess your current proficiency and identify areas of focus for your orientation plan. Please check the appropriate response for each question in the boxes provided. The three columns reflect the three levels of proficiency, and are labeled PRO= Proficient, KNOW= Knowledgeable, and AWARE.

FUNDING SOURCES, CONTRACTS, AND REPORTS	PRO	KNOW	AWARE
Do you know the funding and revenue sources for your LHJ?	☐	☐	☐
Have you had any experience in developing a budget for an agency or organization?	☐	☐	☐
Do you have training in financial management or accounting?	☐	☐	☐
Do you know how to read, interpret and complete the BARS report?	☐	☐	☐
Are you familiar with the annual budgeting cycle and the expectation of administrators for the development and management of the LHJ budget?	☐	☐	☐
Are you responsible for overseeing the development and management of your agency's Consolidated Contract?	☐	☐	☐
If so, do you have knowledge of all the programs funded through the contract, including the various federal and state administrative, fiscal and program requirements, contract deliverables, program reports, and timelines?	☐	☐	☐
Are you responsible for overseeing any other contracts and if so, are you familiar with these contracts?	☐	☐	☐
Do you feel you need additional orientation or training in budgeting to adequately perform your duties as public health administrator?	☐	☐	☐
Do you feel you need additional orientation and training in contract management and monitoring to adequately perform your duties as public health administrator?	☐	☐	☐

Please list other areas needing further orientation, if any:

Tab 5

Public Relations and Community Involvement

Improving the Public's Understanding of the Role of Public Health

One of the seven key elements of the 2000 Public Health Improvement Plan (PHIP) is to successfully communicate important messages to the public. The WSALPHO Communications and Marketing Committee states: *Much can be accomplished when people and organizations band together to solve health problems. Such efforts have persuaded the public to wear seatbelts, stop drinking and driving, and ensure smoke-free environments.* Their 2000 report to the legislature includes the results of a 1999 national poll of people who were asked what they thought *public health* meant. Only 27% identified *programs that maintain healthy living conditions*, while 23% mentioned *health services to the poor*.

All residents of the state benefit from public health services, but few understand the impact public health has on their lives. When the public doesn't understand the services provided by public health, they are less likely to work with public health agencies or programs to solve local health problems. This lack of awareness impedes the public health system's ability to protect and improve health.

DOH, the State Board of Health, and WSALPHO are working together to increase the public's understanding of public health services. This will help community leaders set clear goals for improving health at local levels and through statewide alliances. The next steps outlined in the 2000 PHIP include:

- Increase public understanding of the mission of public health: to protect and improve the health of all people in Washington State.
- Improve the public's understanding of the breadth and depth of public health services, and increase public participation in addressing and solving health problems.
- Obtain a better understanding of what the public needs to know to make good decisions about its health and the health of the community.

Media Relationships

The local health administrator's role usually includes media interviews and legislative contact. (Policies and detailed procedures for communicating with the media and with other key community contacts are outlined in the orientation toolkit.) The process for responding to the media includes three steps: preparing for an interview by gathering all related information, developing your message, planning how to effectively utilize different forms of the media, and preparing for follow-up as a result of media exposure. All public health practitioners should use media contacts to advance public health practice and increase the public's understanding of public health issues and services. Some general tips for responding to a media request are listed below.

- Return their calls quickly
- Learn more about the specific information they are seeking and if possible, why they are calling you
- Ask them who else they have talked to or are trying to contact
- Determine what their timeline is. When do they need the information?
- Confirm what information you will be getting to respond to their request and by when you will contact them.

Keys to Community Involvement

All local health jurisdictions should have a list of community members likely to be influential to local public health and its practice. These key community members will have a unique understanding of local people and health issues (including diverse cultural and special groups). Members of the community should be able to provide knowledge, expertise, volunteers, political support, or even financial support to promote local public health activities or influence others that could provide these resources. They can assist an LHJ in prioritizing programs or services that are valued by the community. These key members could also mount opposition to public health activities and should be considered and consulted early in any planned activity. It is recommended that the new administrators become familiar/acquainted with these key members of the community early in their tenure.

Performance Standards for Community Involvement

The Public Health Performance Standards include several standards and numerous measures to describe and evaluate local and state level involvement of community members. Community and stakeholder involvement is also one of the eight key management practices framework used to organize the performance measures. A couple of examples of standards addressing community involvement are:

- Understanding Health Issues Standard 2; "Information about environmental threats and community health status is collected, analyzed and disseminated at intervals appropriate for the community."
- Prevention is Best: Promoting Healthy Living Standard 2; "Active involvement of community members is sought in addressing prevention priorities."

Risk Communication

Risk communication is a science-based approach for communicating effectively in high concern, low trust, sensitive, or controversial situations. The level of public concern and trust in the responsible organization can characterize every situation. Risk communication is essential when there is high concern and low trust, and highly recommended when there is high concern and high trust.

The following concepts are highlights from the Risk Communications Workshop given by Dr. Vince Covello in spring, 2000. Risk communication has three goals: to increase knowledge and understanding, to enhance trust and credibility, and thirdly, to resolve conflict. Risk communication skills can be grouped into 3 areas: the message (what), the messenger (who), and the media (how).

- **Three tips for effective messages:**
  1. Make your messages simple, short and relevant to your audience
  2. Repeat your 3 key messages often
  3. Always use visuals because they increase attention, recall and understanding

- **Negative words to avoid:** no, not, can't, don't, never, nothing, and none

- **Message Mapping** is a technique for developing and displaying your three key messages and supporting points. Message maps are used as talking points and as the basis for written materials, exhibits and other communications. Message maps contain information designed for varying levels of comprehension, ranging from 6th grade to post-graduate. A group with expertise in four areas; policy, technical, communications and legal develops the messages. Message maps are combined into briefing books and routed to those who will communicate about the issue. The maps need to have a "champion" who maintains them; this is usually the technical expert.

- **Three tips for building trust and credibility:**
  1. Demonstrate empathy and caring in your body language and key messages. Fifty percent of your credibility depends on whether people believe you care about their concerns.
  2. Demonstrate commitment to address people's concerns; expertise in the subject area; and an open, honest approach to handling information. Together, these three factors account for the remaining 50 percent of your credibility.
  3. Remember that credibility is in the eye of the perceiver. Find out who is highly credible with your target audience and align yourself with them, if possible.

- **Negative dominance theory**: (1N = 3P) If you are attacked or accused by a credible source, you need three positive messages to neutralize one negative message. You need one additional positive message to reestablish your credibility.

Self-Assessment of Public Relations and Community Involvement

The following questions will help you assess your current proficiency and identify areas of focus for your orientation plan. Please check the appropriate response for each question in the boxes provided. The three columns reflect the three levels of proficiency, and are labeled PRO= Proficient, KNOW= Knowledgeable, and AWARE.

PUBLIC RELATIONS AND COMMUNITY INVOLVEMENT	PRO	KNOW	AWARE
Do you have experience presenting to large groups of people?	☐	☐	☐
medical professionals?	☐	☐	☐
the general public?	☐	☐	☐
special interest or minority groups?	☐	☐	☐
Do you have experience with risk communication techniques and concepts?	☐	☐	☐
Has a reporter or the media ever interviewed you? (e.g., newspaper, radio, television)	☐	☐	☐
Do you live in the community in which the local health jurisdiction is located?	☐	☐	☐
Are you acquainted with key leaders in this community? (e.g., County Commissioners, mayor, hospital administrator, advisory group leaders, other community leaders)	☐	☐	☐
Have you participated in any organizations or initiatives within this community? (e.g. civic and service organizations, community or neighborhood organizations)	☐	☐	☐
Do you feel you need additional training in communications and public relations to adequately perform your duties as public health administrator?	☐	☐	☐

Please list other areas needing further orientation, if any:

Tab 6

Health Policy Development and Implementation

Policy Development as One of the Three Core Functions

One of the three core functions of public health is policy development, as first described in the 1988 Institute of Medicine report ***The Future of Public Health.*** This responsibility is defined as using data gathered through assessment to develop health policy and recommend programs to carry out those policies. Health policy should result in proposals to support and encourage better health.

In 1989 the Public Health Practice Program Office of the CDC formed a work group to determine the system practices that would be necessary to assure that the core functions of public health were being carried out. Their work resulted in ten organizational practices that must be carried out by a component of the public health system in each locality. Three of these support the function of policy development:

- Advocate for public health, build constituencies and identify resources in the community,
- Set priorities among health needs, and
- Develop plans and policies to address priority needs.

The 1993 Progress Report from the Washington State Core Government Public Health Functions Task Force (included in the orientation toolkit) defines a process for health policy development and clearly articulates the differing roles at the state and local levels.

The Policy Development Process

The development process uses assessment information from many sources including scientific information, information from concerned citizens and providers, concepts of political and organizational feasibility, and community values. It is an open process, involving all public and private sectors by communicating, networking, and building constituencies. The process outlined in the report includes the following steps:

- Define health needs,
- Set priority health issues by analyzing the outcome of assessment,
- Develop policies and plans to address the most important health needs by setting goals and measurable objectives,
- Develop alternative strategies for developing plans, and
- Identify necessary and available resources.

Tools and Methods for Strategic Planning and Policy Implementation

Local health jurisdictions throughout Washington have conducted assessments of community health status. They are being used in a variety of ways to identify and improve the health status of individuals in the community. In some counties the local Board of Health and the leaders in the LHJ jointly establish the priorities for expanded or new public health programs. There are many communities with coalitions for different issues, or with advisory groups that work with the LHJ to analyze the results of assessments, to determine some of the causal factors for the issue, and to plan for

community activation to address the problem. Various tools and methods can be used by these groups of public health and community leaders to increase the effectiveness of their policy development and implementation processes. A few of these methods are described below and referenced in greater detail in the toolkit.

Mobilizing for Action through Planning and Partnership (MAPP) -
http://nacchoweb.naccho.org/MAPP_Home.asp

MAPP is a community-wide strategic planning tool, developed by NACCHO and CDC, for improving community health. Facilitated by public health leadership, this tool helps communities prioritize public health issues and identify resources for addressing them. The process includes four strategic assessments undertaken by the local community: 1) community themes, 2) a local public health system assessment, 3) a community health status assessment, and 4) an evaluation of the forces of change. Because the community's strengths, needs, and desires drive the process, MAPP provides the framework for creating a truly community-driven initiative.

Protocol for Assessing Community Excellence (PACE) -
http://www.bixler.com/naccho/GENERAL261.htm

PACE is also a tool developed by NACCHO to help local communities and health departments conduct a community-based assessment and create an accurate and verifiable profile of the community's status. The methodology takes the user through a series of steps to engage the public, collect necessary and relevant information pertaining to community concerns, rank issues, and set local priorities of action. At the heart are three core processes: developing new relationships with community stakeholders, expanding the understanding of the relationship between human health and the state of the environment, and redefining the leadership role for public health officials.

Public Health Performance Standards and Best Practices -
torie.hernandez@doh.wa.gov

The Revised Standards are a performance measurement system of standards and measures developed by committees of public health practitioners. They include five key areas of public health practice and, for each standard, a set of measures is provided for local and state agencies. The standards and measures crosswalk to the ten essential public health services and the three core functions. By assessing LHJ performance in the five areas of standards, the jurisdiction can set priorities for improving their processes and health status outcomes, and utilize the best practices to assist in the improvement activities.

Turning Point Project -
http://depts.washington.edu/hpap/Performance_Measurement/performance_measurement.html#Turning

This national project based at the University of Washington has developed a process for establishing and implementing performance measures for public health. The *Turning Point Guidebook for Performance Measurement* defines various types of measures and presents tools and methods for planning and implementing performance measurement. The steps in the process include incorporating stakeholder input, promoting top

leadership support, creating a mission, long-term goals, goals, and objectives; formulating short-term goals, devising a simple, manageable approach, and providing technical assistance. The guidebook describing the process in detail is referenced in the accompanying orientation toolkit.

Self-Assessment of Health Policy Development and Implementation

The following questions will help you assess your current proficiency and identify areas of focus for your orientation plan. Please check the appropriate response for each question in the boxes provided. The three columns reflect the three levels of proficiency, and are labeled PRO= Proficient, KNOW= Knowledgeable, and AWARE.

HEALTH POLICY DEVELOPMENT AND IMPLEMENTATION	PRO	KNOW	AWARE
Have you developed mission, goals and objectives for a department or program?	☐	☐	☐
Are you familiar with core functions and the essential services, as they pertain to policy development?	☐	☐	☐
Are you familiar with the development of public health policy at local and state levels, including public health law found in RCWs, WACs, and ordinances?	☐	☐	☐
Do you have experience with facilitation and/or leading specific program planning and evaluation activities?	☐	☐	☐
Are you familiar with the Washington State Public Health Standards and the Best Practices report?	☐	☐	☐
Do you have experience in quality improvement methods or tools?	☐	☐	☐
Are you familiar with using quality standards for assessment of performance or with the use of best practices to improve performance?	☐	☐	☐
Do you feel you need further orientation or training on policy development or implementation to adequately perform your duties as public health administrator?	☐	☐	☐

Please list other areas needing further orientation, if any:

Tab 7

Personnel and Property Management

Personnel Management

This orientation process assumes that the new administrator has prior administrative or management experience, and does not include general management skills and knowledge. This section is included to provide a short overview of this functional area and to provide summaries of specific legislation that managers and leaders, regardless of their industry, are required to follow.

It is the responsibility of the leadership of the local health jurisdiction to provide the direction and support needed by the management team and the staff to fulfill the mission of the LHJ and achieve the highest outcomes possible. Managing in the public sector is both unique in some factors, and yet shares common practices with all other types of healthcare entities. References abound to assist administrators in creating and maintaining a positive work environment. Several references specific to public health management are found in the accompanying orientation toolkit.

Legislation for Personnel Management - There are numerous rules and regulations governing the rights of employees both at the federal and state level. Several of the most important federal regulations are described below, and in greater detail in the toolkit.

Americans with Disabilities Act (ADA) *:* ***http://www.usdoj.gov/crt/ada/adahom1.htm***

Signed into law on July 26 1990, the Americans with Disabilities Act is a wide-ranging legislation intended to make American Society more accessible to people with disabilities. This statute is of relevance in both the hiring of disabled persons and the provision of public services.

Fair Labor Standards Act (FLSA) *):* ***http://www.opm.gov/flsa/index.htm***

A federal law initially passed in 1938 that sets minimum wage, overtime pay, equal pay, record keeping and child labor standards for employers who are covered by the Act.

Family and Medical Leave Act (FMLA) *):* ***www.opm.gov/hrss/html/fmla96.htm***

Signed into law in 1993, the Family and Medical Leave Act entitles eligible employees to take up to 12 weeks of unpaid, job-protected leave in a 12-month period for specified family and medical reasons. The law contains provisions on employer coverage, employee eligibility for benefits, entitlement to leave, maintenance of health benefits during a leave, and job restoration after a leave.

Labor Unions

At least one union contract covers employees of some LHJs, Local 1557 of the Washington State Council of County and City Employers and the American Federation of State, County, and Municipal Employees (AFL-CIO). This union contract covers all of the Wahkiakum County employees, for example, including nurses and mental health therapists.

Self-Assessment of Personnel and Property Management

The following questions will help you assess your current proficiency and identify areas of focus for your orientation plan. Please check the appropriate response for each question in the boxes provided. The three columns reflect the three levels of proficiency, and are labeled PRO= Proficient, KNOW= Knowledgeable, and AWARE.

PERSONNEL AND PROPERTY MANAGEMENT	**PRO**	**KNOW**	**AWARE**
Have you had experience managing other leaders or supervising staff?	☐	☐	☐
Are you familiar with federal legislation regarding treatment of employees such as the Americans with Disabilities Act or the Family and Medical Leave Act?	☐	☐	☐
Have you hired or fired staff under local county government rules?	☐	☐	☐
Have you worked with unions (as an employer)?	☐	☐	☐
Do you feel you need further orientation or training on personnel policies or practices to adequately perform your duties as public health administrator?	☐	☐	☐
Do you feel you need further orientation or training on property management to adequately perform your duties as public health administrator?	☐	☐	☐

Please list other areas needing further orientation, if any:

Tab 8

Information Systems and Technology

Information Systems to Support Local Health Jurisdictions

An emerging role of the local Public Health Administrator is often the responsibility for key decisions affecting the management, use and expansion of IT and telecommunications systems. To be able to fulfill this role, the local health administrator needs to be proficient in using many applications to facilitate and support their own work and the work of other public health personnel. A more general awareness of the types of applications useful for public health and the existing delivery infrastructure will also contribute to more effective decision making.

In Washington State there are a variety of technical telecommunications and electronic information tools used both internally and externally for:

- Communications
- Information and data exchange
- Education

Most public health entities now support their own web-based home page, with a significant amount of information available regarding services and health issues. Today, in fact, much of the documentation, tracking, monitoring and analysis are done in online systems with no paper documentation.

Communications

Through the Information Network for Public Health Officials (INPHO) project, all of the state's 34 LHJs were connected to a high-speed wide area network. Each LHJ is connected full time to a Frame Relay circuit with a minimum 384KB committed information rate. The INPHO network was designed and implemented to expand beyond public health and currently the Washington Department of Information Services (DIS) assumes administration of what is now called the Inter-Governmental Network (IGN), which currently connects all state agencies to the state's 39 counties. Each county is treated as a "point of presence" (similar to the CDC node concept) for network connections, and used for further connections to county departments (such as public health), cities, Indian Tribes, emergency response organizations, and other local government entities. The network is designed as an Intranet using Internet standards such as TCP/IP and SMTP. This network also provides access to the Internet through DIS.

Use of electronic mail, listservs, bulletin boards and calendars are examples of the daily operational communication applications used by the public health workforce. The Internet is also increasingly utilized as a research, education and marketing tool to enhance and deliver public health services.

Several listservs are in place as tools for information and resource sharing, problem solving and policy discussions. The chart below highlights those public health lists that focus on a variety of LHJ workforce needs. All Local Health Administrators are automatically subscribed to the WSALPHO list. More information can be obtained about these lists from contacting listserv owners.

List Serve Matrix for LHJs

Name of List and Description	Primary (PO) and Secondary Owner(SO)	Open/ Closed?	Who's intended to use list?
lhj-fiscal@listserv.wa.gov This electronic discussion group provides an opportunity for local public health staff who have fiscal responsibilities with respect to state contracts to communicate ideas and concerns and share information and resources. The list is primarily open to those at the local level with fiscal responsibility and to others by permission of the list owner.	Lois Speelman	Owner must approve all subscription requests	Local public health staff with fiscal responsibilities.
lhj-ho@listserv.wa.gov This electronic forum provides an opportunity for local health officers across the state to communicate and share information and resources regarding the work they do in public health at the community level.	Maxine Hayes (PO) Terry Bergener (SO)	Owner must add new subscribers	Washington State Local Health Officers and State Health Officer (Others can be included only with permission from the state health officer.)
lhj-oralhealth@listserv.wa.gov The purpose of this listserv is to allow Oral Health program coordinators to have more frequent contact with each other without requiring physical proximity.	Ethel Steinmetz (PO)	Owner must approve all subscription requests	Oral Health Program Coordinators in LHJs.
lhj-vitalrecords@listserv.wa.gov The purpose of this list is to serve state and local registrars and their staffs by providing an electronic means to exchange and answer questions concerning the administration of vital records in Washington State.	Carrie Holbrook (PO) Teresa Jennings (SO) Carol Armstrong (SO)	Owner must approve all subscription requests	This list is intended for use by those engaged in registration, issuance, and data quality issues of birth and death records at LHJs and at DOH.

Name of List and Description	Primary (PO) and Secondary Owner(SO)	Open/ Closed?	Who's intended to use list?
wa-assess@listserv.wa.gov The purpose of wa-assess is to provide an electronic forum for exchange of ideas and information regarding community health assessment in Washington. Although this list is intended to be used primarily by Washington Public Health Assessment Coordinators and other Washington public health officials, this is an open list and anyone can subscribe. Please feel free to post questions, announcements, ideas, and information that you feel might be of interest to the public health assessment community in Washington.	Christie Spice (PO) Julie Alessio (SO) Center for Health Statistics http://www.doh.wa.gov/OS/Vista/HOMEPAGE.HTM		Washington Public Health Assessment Coordinators and other Washington public health officials
wa-comdis@listserv.wa.gov The wa-comdis list may be used to 1) provide alerts about CD threats... 2) share experiences about CD interventions 3) ask for information or analyze trends or 4) announce learning opportunities on communicable disease.	Julie Wicklund (PO) Greg Smith (SO)	Owner must approve all subscription requests	Subscriptions are open to anyone who works for an LHJ, DOH or health care providers selected by these jurisdictions.
wa-phtn@listserv.wa.gov Members on the list function as liaisons with the agency they represent and DOH. They are responsible for informing other members of the workforce in their organizations of relevant events and for informing DOH of those events in which they choose to participate. DOH will provide support services to help locate and pay for sites whenever possible to those interested in attending at a member's request.	Janice Taylor (PO) Janice.Taylor@DOH.WA.GOV Torie Hernandez (SO) (360) 236-4081 (360) 236-4088 (FAX) torie.hernandez@doh.wa.gov	Anyone may subscribe to this list	Membership is open to anyone who would like to receive information about public health distance learning training programs.

Name of List and Description	Primary (PO) and Secondary Owner(SO)	Open/ Closed?	Who's intended to use list?
wsalpho@listserv.wa.gov The purpose of this list is to facilitate communication among the local and state partners of the governmental public health system.	Marie Flake (PO) Marie.Flake@doh.wa.gov Simana Dimitrova (SO) Kay Koth (SO) (360) 236-4088 kay.koth@doh.wa.gov	Owner must approve all subscription requests	Subscribers of this list include: leadership of local health jurisdictions, the director of WSALPHO; leadership of DOH, the director of the State Board of Health, and faculty from the University of Washington's School of Public Health and Community Medicine (SPHCM).
wsalpho-exec@listserv.wa.gov	Joan Brewster (PO) Simana Dimitrova (SO) Kay Koth (SO)	Owner must add new subscribers	WSAPLHO Board and DOH Managers
wsalpho-leg@listserv.wa.gov	Joan Brewster (PO) Simana Dimitrova (SO)	Owner must add new subscribers	
wsalpho-phnd@listserv.wa.gov The wsalpho-phnd list may be used to share experiences, ask for information or analyze trends, and discuss policy or any other issues surrounding public health nursing. It is intended to be used only by public health nursing directors working in local health jurisdictions in Washington state.	Carol Oliver (PO) Carol.Oliver@DOH.WA.GOV Justina Novak (SO)	Owner must add new subscribers	Public Health Nursing Directors in Washington State

Databases and other information systems

Information systems and technologies include databases, applications and internet connectivity. The Department of Health lists over 160 different databases in the Information Resource Directory. The scope ranges from financial to mailing distribution systems. Often databases are linked to applications developed to support local public health functions. Most public health entities now support their own website, with a significant amount of information available regarding services and health issues. The LHJ administrator must be able to use all of these technologies and information systems to support and facilitate their work. Today, in fact, much of the documentation, tracking, monitoring and analysis are done using online systems.

Below is a table describing a few of the most important databases for LHJs and the business contact for more information.

Name of Database	Description	Contact or Website
WIC - CIMS	Supports the Women Infant, and Children program to provide essential nutrition intervention.	Jim Hammond CFH
SHARE (AIDSNET Data Reporting System)	Provides uniform reporting system for LHJs for data related to AIDS prevention and client services provision.	Amy McAferty IDRH
CHILD Profile (CPMENU)	Provides information about and tracks care received by infants at risk with medical, congenital, or social problems.	Janna Halverson MCH
Behavioral Risk Factor Surveillance System (BRFSS)	National annual survey that collects information from adults on health behaviors and preventive practices related to several leading causes of death.	Katrina Wynkoop Simmons Center for Health Statistics
VISTA/PH – Software for Public Health Assessment	A point-and-click software package for analyzing population-based health data (e.g. leading causes of death by age, sex, race & geography).	Julie Alessio, Center for Health Statistics http://www.doh.wa.gov/OS/Vista/HOMEPAGE.HTM

Privacy and Confidentiality of Information

Washington has a comprehensive statute, the Uniform Health Care Information Act [Wash. Rev. Code Ann. § 70.02.005 et seq.], governing the access to and disclosure of health care information maintained by health care providers. Washington also has numerous other laws protecting the confidentiality of health information in specific situations. Some of these apply to entities other than health care providers, such as insurers and governmental agencies. One of the specific conditions covered by privacy legislation is information about individuals with AIDS or HIV. The accompanying toolkit references a manual that provides copies of associated RCWs and WACs, CDC guidelines on security and confidentiality, and sample policies, procedures, and forms that can be adapted by local health jurisdictions for their own use. The Health Insurance

Portability and Accountability Act (HIPAA) also includes extensive regulations for the release of personal medical information by providers and any other agents involved in sharing medical information. New administrators should be familiar with these rules and regulations and the implications for LHJ operations.

Informatics

Informatics is the scientific field that deals with the storage, retrieval, and sharing and optimal use of data, information and knowledge. Over the last decade, informatics specialists have begun shaping a unified information technology framework through the development and advocacy of standards. There are standards available for all aspects of information technology, including hardware, communications, databases and data.

Principles of Public Health Informatics

Four principles, flowing directly from the scope and nature of public health, distinguish informatics from other specialty areas.

- The primary focus of public health informatics should be applications of information science and technology that promote the **health of populations** as opposed to the health of specific individuals.

- The primary focus of public health informatics should be applications of information science and technology that **prevent** disease and injury by altering the conditions or the environment that put populations of individuals at risk.

- Public health informatics should explore the potential for prevention at **all vulnerable points in the causal chains** leading to disease, injury, or disability; applications should not be restricted to particular social, behavioral, or environmental contexts.

- As a discipline, public health informatics should reflect the **governmental context** in which public health is practiced.

Informatics Approach in Washington

For more than five years, Washington has been formulating a unified planning process, following the principles of informatics, to develop an integrated notifiable condition surveillance system. Information systems in public health should be designed cohesively to support common business practices, using common system architecture and data standards. In this way, DOH can develop systems to be used by multiple programs, making more effective use of both the data and the department's information system resources. The work group concluded that DOH must consider the entire notifiable condition surveillance framework, with all its component parts, including the health care industry and local, state and federal health agencies, as a *system*, with a system-wide approach to planning.

Washington Electronic Disease Surveillance System (WEDSS)
http://www.cdc.gov/od/hissb/docs.htm

The planning by the Informatics Project has led to the formation of the Washington Electronic Disease Surveillance System (WEDSS) project. The WEDSS project serves as the umbrella for multiple projects, each intended to address a specific component of the notifiable condition surveillance system. These four projects are: 1) reporting of data from the clinical health care system to the appropriate public health agency and between public health agencies; 2) management of case information; 3) management of aggregated surveillance information; and 4) analysis and dissemination of information. WEDSS also includes a technology infrastructure project to enable all of this information exchange to take place in a secure electronic environment.

Public Health Information Technology Committee (PHIT)

At the February 2000 WSALPHO meeting, DOH gave a presentation on the possibility of redesigning Thurston County's Public Health Issue Management System (PHIMS) and making it available to all local health jurisdictions. Many WSALPHO members expressed a concern that coordination was needed between LHJs and DOH staff considering other automated systems. It was decided that a committee should be formed, chaired by the DOH Chief Technology Information Officer (CTIO), to advise WSALPHO on information technology issues and opportunities to purchase or develop systems that would have potential broad use within LHJs in Washington.

As a result, the joint state and local Public Health Information Technology (PHIT) committee was created to conduct the information systems planning effort, within the context of the Public Health Improvement Plan (PHIP) and under the oversight of the PHIP Steering Committee. As a first step in the planning effort, the PHIT has initiated a high-level review and discussion of business/work processes that occur within all local health agencies. The committee is defining the business/work processes, discussing whether significant and measurable improvements are possible for those processes, and developing priorities for improvement efforts using information technology. The PHIT will disseminate these recommendations broadly in the public health community in Washington, seeking input on the specific priorities. The PHIT will modify its recommendations based on this input and relay them to the PHIP Steering Committee for inclusion in the state's overall public health system improvement process. Further information on the PHIT is available from Gary Schricker, Chief Technology and Information Officer for DOH, at gary.schricker@doh.wa.gov.

Public Health Information Technology Committee (PHIT) cont'd - The PHIT work plan established in 2000 includes the following goals and objectives:

Standards Development	Standards to support business applications: data sharing, current and emerging technology, HIPAA, common data elements, etc.
Create opportunities for System Efficiencies	▪ Disseminate information about local and state technology projects. ▪ Encourage technology-based information exchange wherever possible. ▪ Establish priorities for web-based technology, special networks, information exchange, IT management, coordination of systems, streamline data collection & reporting, etc.
Leverage System Resources	▪ Bulk purchasing ▪ Appropriate technology ▪ Pooling of resource and capacity
Emerging Technology	Make recommendations regarding emerging technology
Training	Collaborate with Workforce Development initiatives

Education - Washington Public Health Training Network (WAPHTN)
http://www.doh.wa.gov/waphtn/

To address both informal (meetings, planning and group problem solving) and formal learning needs (traditional classroom style curriculum), the Internet is used in combination with audio teleconferences, video conferences, satellite teleconferences, a videotape lending library and classroom experiences to increase access for a geographically dispersed workforce.

While the Intergovernmental Network system connects state and local public health agencies for computer applications, other technology infrastructure is more fragmented. Some local health jurisdictions have purchased their own equipment (such as satellite dishes or compressed video), but most of the existing telecommunications systems (other than telephones) are negotiated through partnerships with other health and educational systems. DOH provides access to these resources through the Washington Public Health Training Network.

Self-Assessment of Information Systems and Technology

The following questions will help you assess your current proficiency and identify areas of focus for your orientation plan. Please check the appropriate response for each question in the boxes provided. The three columns reflect the three levels of proficiency, and are labeled PRO= Proficient, KNOW= Knowledgeable, and AWARE.

INFORMATION SYSTEMS AND TECHNOLOGY	PRO	KNOW	AWARE
Do you have experience using a personal computer including email and the internet?	☐	☐	☐
Have you ever participated in a listserv or email discussion group for online conferencing?	☐	☐	☐
Are you familiar with Washington State laws on information privacy and public disclosure, and with the Health Insurance Portability and Accountability Act (HIPAA)?	☐	☐	☐
Are you familiar with key electronic systems available to document and track administrative and clinical public health activities such as CIMS, and VISTA?	☐	☐	☐
Do you have experience with website management and oversight?	☐	☐	☐
Do you feel you need further orientation or training on the use of computers to adequately perform your duties as public health administrator?	☐	☐	☐
Do you feel you need further orientation or training on information systems to adequately perform your duties as public health administrator?	☐	☐	☐

Please list other areas needing further orientation, if any: